

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13312

13338

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>114 Stevenson Lane</u>				d. STREET ADDRESS <u>114 Stevenson Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>GRAHAM</u> Last <u>ANDREAE</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>19 59</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 5, 1959</u>	9. AGE (In years last birthday) <u>-</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days	IF UNDER 24 HRS. Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Norman Andreae</u>				14. MOTHER'S MAIDEN NAME <u>Jean Gowdy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Charles N. Andreae - 114 Stevenson Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> <u>9240</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <u>from Came out of Night Gown, it Twisted Around Neck</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>and Strangled Baby</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Towson</u> <u>Balto.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto 17</u>				24a. REC'D BY REGISTRAR <u>DEC 15 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2062

13339

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadybrook Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shadybrook Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES</i>		4. DATE OF DEATH <i>Dec 12 - 5 - 1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 26, 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Robinsonville</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Arnold</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr Charles M Arnold</i>		Address <i>9216 Liberty Rd.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho - Pneumonia</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral accident</i> DUE TO <i>Generalized Arteriosclerosis</i> (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 days</i> <i>year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from *Dec. 1*, 19*59* to *Dec. 5*, 19*59*, that I last saw the deceased alive on *Dec. 5*, 19*59*, and that death occurred at *7:30 PM*, from the causes and on the date stated above.

ACTUAL SIGNATURE <i>Wm. M. Fort</i>	ADDRESS (Street, city or town, state) <i>6 Sutton Ave. Catonsville 28</i>	DATE SIGNED <i>Dec 28</i>
PHYSICIAN'S NAME (Type) <i>Wm. M. Fort</i>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 8, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Young Byers</i>		ADDRESS <i>8728 Liberty Rd.</i>	
24a. REC'D BY REGISTRAR <i>DEC 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13340

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson				c. LENGTH OF STAY IN 1b 6 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle CLAYTON Last ARTHUR				4. DATE OF DEATH Month DECEMBER Day 8 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/14/05	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) MARYLAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY CITY WATER DEPT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES E. ARTHUR				14. MOTHER'S MAIDEN NAME CATHERINE JOHNSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 214-03-0281		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/3/59 to 12/8/59 , that I last saw the deceased alive on 12/8/59 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____							
ACTUAL SIGNATURE _____ M.D. William Newcomer, M.D. Superintendent							
PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Radio 17th				24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. King	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTIN STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

137412

10/11/54

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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1990

CERTIFICATE OF DEATH

Reg. Dist. No.

13315

13341

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| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gwynn Oak</u> | | c. LENGTH OF STAY IN 1b <u>11 mo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO MD.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FUGSBURG HOME</u> | | d. STREET ADDRESS <u>9311 St. George Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mathilda Marie ASHAVER</u> | | 4. DATE OF DEATH <u>Dec 22, 1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/9/1879</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Charles Pleines</u> | | 14. MOTHER'S MAIDEN NAME <u>Rose Beck</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Reoras Ave. Home Campidder</u> | | Address <u>Campidder</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis.</u>
DUE TO (b) <u>Hypertensive Heart Disease</u>
DUE TO (c) <u>—</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input checked="" type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Dec. 22nd</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 21 - 19 59</u> , and that death occurred at <u>6:52 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Earl L. Chambers</u> | | DATE SIGNED <u>7-14-12-23-59</u> | |
| PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u> | | <u>4108 Liberty Hts. Balto - 7-14-12-23-59</u> | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/26/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>PA. Heemann</u> | | ADDRESS <u>6067 Harf Rd</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 28 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haux</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18315

DEPARTMENT OF STATE

18315



[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

13342

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pikesville</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>x Pikesville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>7606 - 7 Mile Lane</u> | | | | d. STREET ADDRESS
<u>7606 - 7 Mile Lane</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Florence</u> Middle <u>Bach</u> Last <u>Bach</u> | | | | 4. DATE OF DEATH
Month <u>12</u> - Day <u>13</u> - Year <u>1959</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-30-1894</u> | 9. AGE (In years last birthday)
<u>65</u> yrs. | IF UNDER 1 YEAR
Months <u>65</u> | IF UNDER 24 HRS.
Days <u>65</u> Hours <u>65</u> Min. <u>65</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Phila - Pa</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Moses Middleman</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Blara</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | INFORMANT
<u>Regina Hyman - same</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> about <u>1 1/2 hr.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertension C.V.D.</u> about <u>1 yr.</u>
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>about</u> , 19 <u>58</u> , to <u>Dec 13, 1959</u> , that I last saw the deceased alive on <u>Dec. 12, 1959</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>888 W. Lombard St. Balto. Md.</u> DATE SIGNED <u>12/14/59</u>
ACTUAL SIGNATURE <u>G. Highstein</u> M.D.
PHYSICIAN'S NAME (Type) <u>G. HIGHSTEIN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-15-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hebrew Friendship</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jack Lewis Mc</u> | | ADDRESS
<u>2100 Eutaw Pl</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 17 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | |

15918

RECEIVED STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

15918

1

[Faint, illegible handwritten text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The handwriting is very light and difficult to decipher.]

13343

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN lb
40 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First EVERETT Middle G. Last BAKER | | | | 4. DATE OF DEATH
Month DECEMBER Day 25 Year 19 59 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/16/90 | |
| 9. AGE (In years last birthday)
69 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Buffalo, New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Detective | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Dept. Stores | | | |
| 13. FATHER'S NAME
George Baker | | | | 14. MOTHER'S MAIDEN NAME
Anna UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
212-12-2714 | | | |
| 17. INFORMANT
Clin. Rec. VA Hosp. Balto, Md. Ft. Howard Division | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON TO LUNGS AND LIVER
153.8 DEXX LIVER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
6 YEARS | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11/15/ 1959 to 12/25/ 1959 , and that death occurred at 4:10A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Walter C. Goldstein, M.D. VAH, BALTO, MD. FORT HOWARD DIVISION
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D. VAH, BALTO, MD. FT. HOWARD DIVISION 12/25/59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
12/28/59 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
HENRY SANDER & SONS, INC. North Ave. & Broadway Baltimore, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE DEC 28 '59 | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur E. [Signature] | | | | | | | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13343

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13318

13344

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton | | c. LENGTH OF STAY IN 1b 63 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodbrook | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Laura Hanson Baldwin | | 4. DATE OF DEATH Dec. 10 1959 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 27, 1870 |
| 9. AGE (In years last birthday) 89 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Aquilla Brown Hanson | | 14. MOTHER'S MAIDEN NAME Elizabeth Middleton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Mr. Summerfield Baldwin | |
| 17. ADDRESS Above | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition
DUE TO 334X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis
DUE TO General arteriosclerosis
(c) Several years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 4 , 19 41 , to Dec 10 , 19 59 , that I last saw the deceased alive on Dec 10 , 19 59 , and that death occurred at 9:35 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John Tilden Howard | | ADDRESS (Street, city or town, state) 12 East Eager St, Balt, Md | |
| PHYSICIAN'S NAME (Type) John Tilden Howard, M. D. | | DATE SIGNED Dec 11, 59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-12-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Greenmount | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Baltimore 12, Md. | |
| 24a. REC'D BY REGISTRAR DEC 14 59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hays | |

CERTIFICATE OF DEATH

Residence

Age

Sex

Marital Status

Occupation

Education

Language

Religion

Birth Date

Birth Place

Death Date

Time

Cause

Place

Attending Physician

Medical Examiner

Signature of Medical Examiner

Signature of Registrar

13345

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pikesville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Pikesville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4618 Old Court Road | | | | d. STREET ADDRESS
4618 Old Court Road | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Daisy First Dean Middle Bange Last | | | | 4. DATE OF DEATH Dec. 2, 1959 Month Day Year | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 11, 1881 | 9. AGE (In years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
George T. Bean | | | | 14. MOTHER'S MAIDEN NAME
Griselda Warfield | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT George Bange, Pikesville 8, Md. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardiac Disease
252.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Toxic goitre DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/13, 1959 , to 12/2, 1959 , that I last saw the deceased alive on 12/2, 1959 , and that death occurred at 1:05 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Grace G. Jones | | | | ADDRESS (Street, city or town, state) 12 Walther Ave | | DATE SIGNED 12/3/59 | |
| PHYSICIAN'S NAME (Type) Dr. Grace G. Jones Baltimore 8 - Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 5, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Deer Park | | 22d. LOCATION (City, town, or county) (State)
Reisterstown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J.F. Eline & Sons, Reisterstown, Md. | | | | 24a. REC'D BY REGISTRAR
DEC 7 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13346

13320

32

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|--|--------------------------------------|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Baltimore</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Balto. City</u> ✓ | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Mt. Wilson</u> | | LENGTH OF STAY (in this place)
<u>68 mo.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Baltimore City 31,</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Mt. Wilson State Hospital</u> | | | | STREET ADDRESS (If rural give location)
<u>1920 Bank St 3vol-4</u> | | | |
| 3. NAME OF DECEASED (Type or Print)
(First) <u>Martin</u> (Middle) <u>Barrett Sr.</u> (Last) | | | | 4. DATE OF DEATH (Month) <u>12</u> (Day) <u>7</u> (Year) <u>1954</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>M</u> | 8. DATE OF BIRTH
<u>4/11/1887</u> | 9. AGE last birthday
<u>72</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Huckster</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Grocery</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Bartley Barrett</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Flynn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO.
<u>213-34-3544</u> | | 17. INFORMANT & ADDRESS <u>Hospital Records</u>
<u>Mt. Wilson State Hospital</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 002X IMMEDIATE CAUSE (A) <u>Far Advanced Pulmonary Tuberculosis</u> | | | | | | <u>6 yrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2/24</u> , 19 <u>54</u> , to <u>12/7</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>12/7</u> , 19 <u>54</u> , and that death occurred at <u>4:35 A.</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Wm. Newcomer, M.D.</u> | | | | ADDRESS (Street, city, town, state)
<u>Superintendent, Mt. Wilson, Md.</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Dec. 10, 1959</u> | | NAME OF CEMETERY OR CREMATORY
<u>Mt. Carmel</u> | | LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>DEC 10 '59</u> | | REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Jelly & Zerkler Inc.</u> ADDRESS
<u>1901 Eastern Ave.</u> | | | |

13347

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN 1b
6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle E Last BAUGHER | | | | 4. DATE OF DEATH
Month December Day 28 Year 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
December 1, 1895 | |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR
Months 64 Days 64 Hours 64 Min. | | 11. BIRTHPLACE (State or foreign country)
Balto. Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY
B&O Railroad | | | |
| 13. FATHER'S NAME
William Rebecker Baugher | | | | 14. MOTHER'S MARRIAGE NAME
Ida Rose Lewis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
705-05-7489 | | | |
| 17. INFORMANT
Clin. Rec. VA Hosp Balto Md Ft Howard Division | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF ADRENAL GLAND RIGHT
1950
DUE TO METASTATIC CARCINOMA TO LIVER, LUNGS AND PERIAORTIC AND TRACHEOBRONCHIAL LYMPH NODES
(b) BRONCHOPNEUMONIA
(c) EDEMA OF THE LUNGS
INTERVAL BETWEEN ONSET AND DEATH
Unknown
3 DAYS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. VA p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 22, 1959 to December 28, 1959 and that death occurred at 12:40 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) VAH BALTO MD FT HOWARD DIVISION DATE SIGNED 12/28/59 | | | | | | | |
| ACTUAL SIGNATURE Clovis M Snyder M.D. VAH BALTO MD FT HOWARD DIVISION | | | | | | | |
| PHYSICIAN'S NAME (Type) CLOVIS M SNYDER VAH BALTO MD FT HOWARD DIVISION 12/28/59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
December 31, 1959 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frank H Newell Inc. Reisterstown Rd & Waldron Ave | | | | 24a. REC'D BY REGISTRAR
DEC 30 '59 | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | | 24c. DATE
DEC 30 '59 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13345

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Place of registration: _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G253 12/9/59 iwk

13348

CERTIFICATE OF DEATH

Reg. Dist. No.

13322

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | c. LENGTH OF STAY IN 1b 8 wks. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. | | 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 STUART ST. (Home) | | d. STREET ADDRESS 263 S. CONKLING ST. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) THERESA First Middle Last | | 4. DATE OF DEATH DEC. Month Day Year 4 1959 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG 24, 1884 | |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY MD. | |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME LOUIS RAW | | 14. MOTHER'S MAIDEN NAME THERESA KURTZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. NONE | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 151X DUE TO Carcinoma of Stomach metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach metastases DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from SEPT. 15, 1959 , to DEC. 7, 1959 , that I last saw the deceased alive on Dec. 7, 1959 , and that death occurred at 4:15 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John G. Orth | | ADDRESS (Street, city or town, state) 8019 PHILA. RD. M.D. | |
| PHYSICIAN'S NAME (Type) JOHN G. ORTH | | DATE SIGNED BALTO. 6, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DEC. 8, 1959 | | 22b. DATE THEREOF DEC. 8, 1959 | |
| 22c. NAME OF CEMETERY ZION LUTH. CHURCH | | 22d. LOCATION (City, town, or county) (State) BALTO. CO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann | | ADDRESS 3218 HUDSON ST. | |
| 24a. REC'D BY REGISTRAR DEC 7 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

CENTRAL STATE OF DEATH

1936

MD

BALTO

ESSEX

1936

BALTO

ST. STREET

ST. STREET

THREE

THREE

FEMALE WHITE

FEMALE WHITE

AT HOME

AT HOME

LOUIS RAY

LOUIS RAY

NO

NO

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial/cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
13349
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 4 Film G253 12-14-59 et
CERTIFICATE OF DEATH

13323

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS | | c. LENGTH OF STAY IN 1b 2yrs 8mo. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | 3v01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING SCHOOL | | d. STREET ADDRESS 135 N. Chapel Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARCELLO ANGELO BLACK | | 4. DATE OF DEATH Month Day Year December 5, 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 27, 1956 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME JAMES C. BLACK | | 14. MOTHER'S MAIDEN NAME ESTELLE L. WILSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | |
| INFORMANT chart - Rosewood St. Tr. School Owings Mills Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) rapid decomposition of hydrocephalus
752X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congenital internal hydrocephalus & severe mental deficiency DUE TO (c) — | | INTERVAL BETWEEN ONSET AND DEATH 2da
since birth 3yr. 9mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spastic quadriplegia Generalized convulsions | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from APRIL 12 , 19 57 to Dec 5 , 19 59 , that I last saw the deceased alive on Dec 5 , 19 59 , and that death occurred at 3:35 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Olive Reid Harris, MD | | ADDRESS (Street, city or town, state) Owings Mills, Maryland DATE SIGNED Dec 5, 1959 | |
| PHYSICIAN'S NAME (Type) Olive Reid Harris, M.D. | | Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12/8/59 | 22c. NAME OF CEMETERY OR CREMATORY MT. GARY Cem. | 22d. LOCATION (City, town, or county) (State) Cedar Hill Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson | | 24a. RECEIVED BY REGISTRAR DEC 8 1959 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | |

CERTIFICATE OF DEATH

1933

1933

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

[The body of the certificate contains several lines of extremely faint, illegible text, likely due to fading or bleed-through from the reverse side. The text appears to follow a standard form layout for a death certificate.]

CERTIFICATE OF DEATH

Reg. Dist. No.

13324

13350

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Balto. Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Balto. City</i> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. Md</i> 3001-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Paradise Conv. Home</i> | | d. STREET ADDRESS <i>821 Stricker St.</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Bloom</i> Last | | 4. DATE OF DEATH Month <i>Dec.</i> Day <i>20</i> Year <i>1959</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>12/30/1879</i> |
| 9. AGE (In years last birthday) <i>79</i> yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i> | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Granville Bloom</i> | | 14. MOTHER'S MAIDEN NAME <i>Hester Webster</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>INFORMANT Evelyn Carr-Catonsville Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO <i>Hemiplegia left</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Vascular Accident.</i>
(c) <i>Degenerative Heart Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>June 1958</i> to <i>12/20/59</i> , that I last saw the deceased alive on <i>12/20/59</i> , 19 <i>59</i> , and that death occurred at <i>8:05 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>W. F. McGroth</i> M.D. | | ADDRESS (Street, city or town, state) <i>1303 Frederick Rd Catonsville 28 Md</i> | |
| DATE SIGNED <i>12/21/59</i> | | | |
| PHYSICIAN'S NAME (Type) <i>W. F. McGroth</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>12/24/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Salem Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Winfield-Carroll Co. Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Nutter & Son</i> ADDRESS <i>Catonsville - 28</i> | | 24a. REC'D BY REGISTRAR DATE <i>DEC 28 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE OF BIRTH OF DEATH

1935

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

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DATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13351

CERTIFICATE OF DEATH

Reg. Dist. No.

13325

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH Rosewood State Training School | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Baltimore | o. STATE MARYLAND | b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills, Md. | c. LENGTH OF STAY IN 1b
5 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
West Hyattsville, Maryland | 16 15-2 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rosewood State Training School | | d. STREET ADDRESS
5714 16th Avenue | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Keith Middle Ian Last Bond | | 4. DATE OF DEATH
Month 12 Day 14 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/25/52 |
| 9. AGE (In years last birthday)
7 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 14 Hours 19 Min. | 11. IF UNDER 24 HRS.
Months 7 Days 14 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
--- | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | 11. BIRTHPLACE (State or foreign country)
Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Normond E. Bond | | 14. MOTHER'S MAIDEN NAME
Shirley Sybilia Cavelier | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
--- | |
| 17. INFORMANT
Rosewood Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia and pulmonary abscesses, left complicated by laryngeal edema
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism with intersegmental septal defect | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:50p M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Baltimore 14, Md DATE SIGNED 12/15/59 | | | |
| ACTUAL SIGNATURE Pet W. Rieckert | | M.D. Pathologist | |
| PHYSICIAN'S NAME (Type) Peter W. Rieckert | | Baltimore 14, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 17-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rosewood Cem | | 22d. LOCATION (City, town, or county) (State)
Owings Mills Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. F. Elmer - Sons, Rustertown Md | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Harris | |

1261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13326

13352

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. LENGTH OF STAY IN 1b
5 Months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
CATON RIDGE NURSING HOME | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First HENRY Middle BOWERS Last BOWERS | | 4. DATE OF DEATH
Month 12 Day 20 Year 1959 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
OCT 16, 1884 |
| 9. AGE (In years lost birthday) 75 yrs. | | 10. IF UNDER 1 YEAR
Months 2 Days 4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Elevator operator | | 10b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE, MD | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Bowers | | 14. MOTHER'S MAIDEN NAME
Theresa ROMOSER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-09-5512 | |
| 17. INFORMANT
Miss Janet Bowers | | Address
3042 Edgewood Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. 19 p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 24, 1959 , to Dec 20, 1959 , that I last saw the deceased alive on Dec 20, 1959 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Harry C. Knipp M.D. | | ADDRESS (Street, city or town, state)
4116 Edmondson Ave Baltimore, 29, Md. | |
| DATE SIGNED
12/21/59 | | | |
| PHYSICIAN'S NAME (Type)
HARRY C. KNIPP M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
12-23-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEM. | | 22d. LOCATION (City, town, or county) (State)
Baltimore MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
David R. Martin | | 24a. REC'D BY REGISTRAR
DEC 28 '59 | |
| ADDRESS
1902 Goutow Place | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13353

CERTIFICATE OF DEATH

13327

Reg. Dist. No.

| | | | |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RANDALLSTOWN RURAL</u> | | c. LENGTH OF STAY in 1b
<u>5 DAYS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>NEW WINDSOR</u> | | d. STREET ADDRESS
<u>UNION BRIDGE ROAD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
✓ <u>private residence</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>MARY ANN BOWMAN</u> | | 4. DATE OF DEATH
Month Day Year
<u>DEC 20 1959</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>AUG 4 - 1911</u> |
| 9. AGE (In years last birthday)
<u>48</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>STEINER WACHTER</u> | | 14. MOTHER'S MAIDEN NAME
<u>PATSY STOFFER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>220-18-3315</u> | |
| 17. INFORMANT
<u>CLETUS BOWMAN</u> | | Address
<u>NEW WINDSOR MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA CERVIX</u>
<u>171X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) <u>GENERALIZED CARCINOMATOSIS</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>5-6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EDEMA</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>7/12/19</u> , 19 <u>59</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Thomas C. Webster</u> | | ADDRESS (Street, city or town, state)
<u>111 W. MINUMENT ST</u> | |
| PHYSICIAN'S NAME (Type)
<u>THOMAS C. WEBSTER</u> | | DATE SIGNED
<u>12/20/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>12/22/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>PIPE CREEK</u> | 22d. LOCATION (City, town, or county) (State)
<u>CARROLL CO MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>DR Hartzler & Sons</u> | | ADDRESS
<u>New Windsor Md</u> | |
| 24a. REC'D BY REGISTRAR
DATE
<u>DEC 28 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Harts</u> | |

THIS IS A PRELIMINARY REPORT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18. IT IS TO BE DESTROYED AFTER 10 YEARS. IF IT IS NOT DESTROYED BY THAT TIME, IT IS TO BE DESTROYED BY THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18.

10-10-10

13353

CERTIFICATE OF DEATH

10-10-10

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
[Name] | | 2. SEX
<input type="checkbox"/> Male <input type="checkbox"/> Female | |
| 3. AGE
[Age] | | 4. RACE
[Race] | |
| 5. DATE OF BIRTH
[Date] | | 6. PLACE OF BIRTH
[Place] | |
| 7. DATE OF DEATH
[Date] | | 8. PLACE OF DEATH
[Place] | |
| 9. TIME OF DEATH
[Time] | | 10. CAUSE OF DEATH
[Cause] | |
| 11. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined | | 12. MEDICAL HISTORY
[History] | |
| 13. SIGNATURE OF DECEASED
[Signature] | | 14. SIGNATURE OF WITNESS
[Signature] | |
| 15. SIGNATURE OF PHYSICIAN
[Signature] | | 16. SIGNATURE OF CORONER
[Signature] | |
| 17. SIGNATURE OF JUDGE
[Signature] | | 18. SIGNATURE OF CLERK
[Signature] | |

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i> | | c. LENGTH OF STAY IN 1b <i>8 1/2 mo</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Clifton</i> Middle <i>Clark</i> Last <i>Brown</i> | | 4. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>1959</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr 1-1959</i> |
| 9. AGE (In years last birthday) <i>8 1/2 mo</i> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>University Hospital</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Walter Clark Brown</i> | | 14. MOTHER'S MAIDEN NAME <i>Martha Ellen Under</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mo. Nelson Brown</i> | | Address <i>Fallston Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Fulminating Broncho-</i>
<i>491X</i> DUE TO <i>pneumonia</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>12/15</i> , 19 <i>59</i> to <i>12/16</i> , 19 <i>59</i> that I last saw the deceased alive on <i>12/15</i> , 19 <i>59</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Clifford F. Hudson</i> M.D. | | ADDRESS (Street, city or town, state) <i>FORK MD</i> | |
| PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>Dec 19 1959</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Liberhardt Ave</i> | 22d. LOCATION (City, town, or county) (State) <i>Benson Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer</i> | | ADDRESS <i>Benson Md</i> | |
| 24a. REC'D BY REGISTRAR <i>DEC 21 59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13355

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Cockeysville, Md.

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Box 273 Falls Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Cockeysville, Md.

STREET ADDRESS

Box 273 Falls Rd.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Elias Herman Brown

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Dec 5 19 59

5. SEX:

Male

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

8. DATE OF BIRTH:

Aug 12 1888

9. AGE last birthday: yrs.

71

10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

Dry Goods

11. BIRTHPLACE (State or foreign country):

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY:

USA

13. FATHER'S NAME:

Elias Herman Brown

14. MOTHER'S MAIDEN NAME:

Florence Hardcastle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):

Yes World War I

16. SOCIAL SECURITY No.:

215-05-5755

17. INFORMANT & ADDRESS:

Son, Elias Herman Brown

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a)

DUE TO

Myocardial Infarction

Interval Between Onset And Death 1951 + 36 mos.

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Nephrosclerosis due to

2 years

(c)

Arteriosclerotic CV Dis

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 5, 1959, to Dec 5, 1959, that I last saw the deceased

alive on Dec 5, 1959 and that death occurred at 5:45 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

12/8/1959

NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

LOCATION (City, town, or county)

Pikesville, Maryland

(State)

DATE REC'D BY LOCAL REGISTRAR

DEC 8 '59

REGISTRAR'S SIGNATURE

Charles E. France

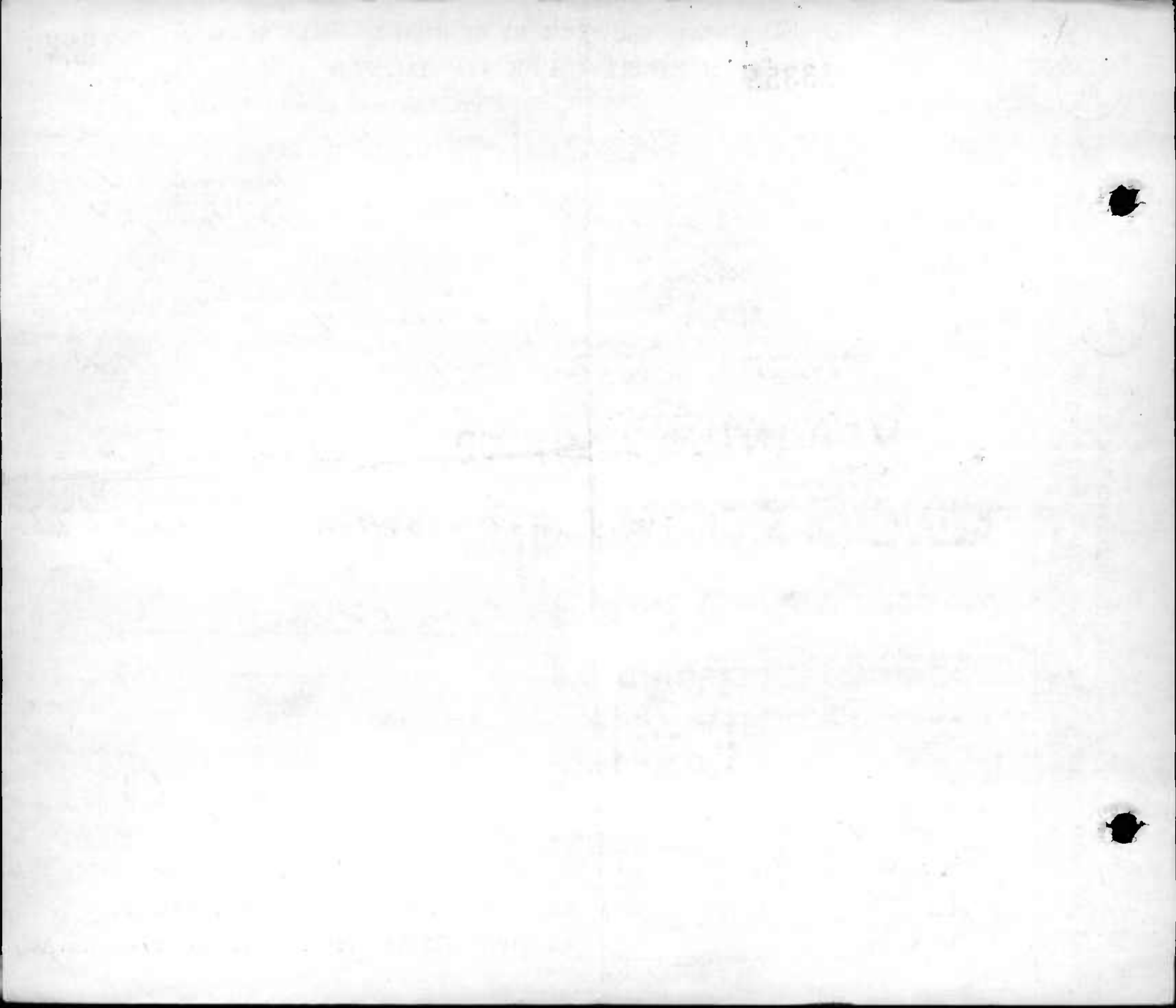
24. FUNERAL DIRECTOR

Ellsworth Armacost-4600 Liberty Hgts. Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13356
CERTIFICATE OF DEATH

Reg. Dist. No.

13330

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>8208 Harford Rd.</u> | | d. STREET ADDRESS
<u>8208 Harford Rd.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Victor</u> Middle <u>Bucher</u> Last <u>Bucher</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>19</u> Year <u>1959</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 6, 1893</u> |
| 9. AGE (In years last birthday) yrs.
<u>66</u> | | 10. IF UNDER 1 YEAR
Months <u>3</u> Days <u>19</u> Hours <u>59</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>truck driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Benjamin B. Bucher</u> | | 14. MOTHER'S MARRIED NAME
<u>Laura V. Marple</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY NO.
<u>217-01-6864</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Cirrhosis of Liver</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 months</u>
(c) <u>3 months</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u>
p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 17, 1959</u> to <u>Dec. 17, 1959</u> , that I last saw the deceased alive on <u>Dec. 17, 1959</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Harold H. Burns</u> | | DATE SIGNED <u>8106 Harford Rd. #4 12-21-59</u> | |
| PHYSICIAN'S NAME (Type) <u>Harold H. Burns M.D.</u> | | <u>Balto. # 2 Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-22-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. John's Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | ADDRESS
<u>5305 Harford Rd.</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>DEC 23 59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>William S. Hays</u> | |

1880

13358

CERTIFICATE

Ballman



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13331

13328

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | c. LENGTH OF STAY IN Yr
15 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
53 Dundalk | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Residence, 7638 Old Battle Grove Rd. | | d. STREET ADDRESS
7638 Old Battle Grove Rd. | |
| 3. NAME OF DECEASED
(Type or print)
Walter | | 4. DATE OF DEATH
Month Dec. Day 8 Year 19 9 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 13, 1894 |
| 9. AGE (In years not birthday)
65 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Coal Miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Pa. Mines | 11. BIRTHPLACE (State or foreign country)
Poland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO.
169-03-5710 | | 17. INFORMANT
Address Mrs. Cecilia Budny 7638 Old Battle G.r. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
30 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Jack P. Collins | | DATE SIGNED
12-9-57 | |
| EXAMINER'S NAME (Type)
Jack P. Collins | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-11-59 | 22c. NAME OF CEMETERY OR CREMATORY
Holy Cross Natl. Cem. | 22d. LOCATION (City, town, or county) (State)
German Hill Rd. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Duda | | ADDRESS
7922 Wise Ave. 22, Md. | |
| 24a. REC'D BY REGISTRAR
DEC 11 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hays | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



EX-100-04511

RECEIVED
JAN 10 1964
STATE DEPT. OF HEALTH
DIVISION OF VITAL RECORDS
1000 CALVERT STREET
BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13324

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
[REDACTED] | | 2. SEX
[REDACTED] | |
| 3. AGE
[REDACTED] | | 4. DATE OF BIRTH
[REDACTED] | |
| 5. PLACE OF BIRTH
[REDACTED] | | 6. OCCUPATION
[REDACTED] | |
| 7. MARITAL STATUS
[REDACTED] | | 8. EDUCATION
[REDACTED] | |
| 9. PRESENT RESIDENCE
[REDACTED] | | 10. DATE OF DEATH
[REDACTED] | |
| 11. CAUSE OF DEATH
[REDACTED] | | 12. MANNER OF DEATH
[REDACTED] | |
| 13. SIGNATURE OF MEDICAL EXAMINER
[REDACTED] | | 14. SIGNATURE OF WITNESS
[REDACTED] | |
| 15. SIGNATURE OF REGISTRAR
[REDACTED] | | 16. SIGNATURE OF CLERK
[REDACTED] | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13352

Reg. Dist. No.

13357

| | | | |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> | | c. LENGTH OF STAY IN 1b <u>5 min.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beckleysville Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Raymond Bull</u> | | 4. DATE OF DEATH <u>Dec. 7 1959</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 8, 1914</u> |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Transit Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Samuel Jacob Bull</u> | | 14. MOTHER'S MAIDEN NAME <u>Beulah Shaffer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>M. Adeline Bull, Hampstead, Md. R.D.</u> | |
| 17. INFORMANT <u>M. Adeline Bull</u> | | Address <u>Hampstead, Md. R.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Crushing injury of chest, compound fracture</u>
819X DUE TO <u>lower right leg, numerous lacerations</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____
DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck a bridge abutment.</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>10.30 12/7/59</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | | 20f. (City or town) <u>Beckleysville, Balto., Md.</u> (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>R. M. France</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>A. M. France</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/10/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Parkton, Md. R.D.</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Forster, New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 14 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE _____ | | DATE SIGNED <u>12/8/59</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13358

CERTIFICATE OF DEATH

13333

Reg. Dist. No.

| | | | |
|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodlawn</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodlawn</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>5534 Clifton Ave. #7.</u> | | d. STREET ADDRESS
<u>5534 Clifton Ave.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LEROY M. Burch JR</u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>22</u> Year <u>1959</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-19-18</u> |
| 9. AGE (In years last birthday)
<u>41</u> yrs. | | IF UNDER 1 YEAR: Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>Leroy M. Burch, Sr.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Walker.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>215-05-1720</u> | |
| 17. INFORMANT
<u>Mrs. Mildred Burch</u> | | Address
<u>5534 Clifton</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Tracheal obstruction</u>
353.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Post-operative edema of the neck.</u>
(c) <u>Epileptic convulsions</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Narcolepsy</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12-6-</u> , 19 <u>59</u> , to <u>12-19-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-21-</u> , 19 <u>59</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>C. Vela</u> | | DATE SIGNED
<u>12-22-59</u> | |
| PHYSICIAN'S NAME (Type)
<u>M.D. Maryland Hem Hospital</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Dec. 26, 1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Meadow Ridge</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Elkridge Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John T. Stansbury</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 28 '59</u> | |
| ADDRESS
<u>6411 Windsor Mill RD.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13329

CERTIFICATE OF DEATH

13334

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Baltimore</u> | | STATE <u>Md.</u> COUNTY <u>Baltimore</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| CITY OR TOWN <u>Turners Station</u> | | LENGTH OF STAY (In this place) | | CITY OR TOWN <u>Turners Station</u> | | STREET ADDRESS (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 6 Maryland Ave. # 22</u> | | | | STREET ADDRESS <u>Box 6 Maryland Ave. # 22.</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>JOHN</u> (First) <u>FREDERICK</u> (Middle) <u>BURKHARDT</u> (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Dec.</u> <u>28,</u> <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>May 18, 1892</u> | 9. AGE last birthday
<u>67</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Amer. Smelt & Ref.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles Burkhardt</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Florence Schneider</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>-----</u> | | 17. INFORMANT & ADDRESS
<u>Louise U. Burkhardt</u> <u>Same.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 443X IMMEDIATE CAUSE (A) <u>Cerebro-Vascular accident</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hours</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C-V Disease</u> | | | | <u>10 years</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
<u>Chr. Emphysema with asthma</u> | | | | <u>20 years</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 23</u> to <u>Dec 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>59</u> , and that death occurred at <u>8:12 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>J. Morrison</u> | | M.D.
<u>3 Kinship Rd Balto 22</u> | | ADDRESS (Street, city, town, state)
<u>30 Dec '59</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>12-31-59.</u> | | NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cem.</u> | | LOCATION (City, town, or county) (State)
<u>4430 Belair Rd. Balto. Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE
<u>Charles J. Seiler</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>401 S. CONKLING ST.</u> | | ADDRESS
<u>BALTO, MD.</u> | |
| DATE <u>DEC 31 '59</u> | | | | | | | |

CERTIFICATE OF DEATH

13322

Registration No. 13322

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED
 JOHN J. HARRIS</p> | | <p>2. LAST KNOWN RESIDENCE
 1234 E. BALTIMORE ST.
 BALTIMORE, MD.</p> | |
| <p>3. DATE OF DEATH
 JANUARY 15, 1922</p> | | <p>4. PLACE OF DEATH
 HOME</p> | |
| <p>5. SEX
 MALE</p> | | <p>6. AGE
 65</p> | |
| <p>7. OCCUPATION
 LABORER</p> | | <p>8. CAUSE OF DEATH
 HEART DISEASE</p> | |
| <p>9. MEDICAL HISTORY
 HYPERTENSION</p> | | <p>10. SIGNATURE OF PHYSICIAN
 J. H. HARRIS</p> | |
| <p>11. SIGNATURE OF REGISTRAR
 J. H. HARRIS</p> | | <p>12. SIGNATURE OF WITNESSES
 J. H. HARRIS</p> | |

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. THE DECEASED IS IDENTIFIED BY THE NAME AND ADDRESS OF THE LAST KNOWN RESIDENCE. THE CAUSE OF DEATH IS TO BE STATED IN AS MUCH DETAIL AS POSSIBLE. THE SIGNATURE OF THE PHYSICIAN IS REQUIRED. THE SIGNATURE OF THE REGISTRAR IS ALSO REQUIRED. THE SIGNATURE OF THE WITNESSES IS ALSO REQUIRED. THE DATE OF DEATH IS TO BE STATED. THE SEX AND AGE OF THE DECEASED ARE TO BE STATED. THE OCCUPATION OF THE DECEASED IS TO BE STATED. THE MEDICAL HISTORY OF THE DECEASED IS TO BE STATED. THE PLACE OF DEATH IS TO BE STATED. THE LAST KNOWN RESIDENCE OF THE DECEASED IS TO BE STATED. THE NAME OF THE DECEASED IS TO BE STATED.

13359

CERTIFICATE OF DEATH

Reg. Dist. No.

13335

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graystone Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William J. Burns</u> | | 4. DATE OF DEATH <u>December 28, 1959</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 19, 1868</u> |
| 9. AGE (In years last birthday) <u>91</u> yrs. | | 10. IF UNDER 1 YEAR <u>1</u> MONTHS <u>1</u> DAY <u>1</u> HOUR <u>1</u> MIN. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Wesley Burns</u> | | 14. MOTHER'S MAIDEN NAME <u>Eliza Cooper</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Informant</u> | |
| 17. ADDRESS <u>Canal Burns, White Hall, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>450.0 Cardiac Thrombosis</u>
DUE TO (b) <u>Arterio - Sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <u>years</u>
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 19, 49</u> to <u>Dec 28, 1959</u> that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>59</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Wilmer Bortner</u> | | ADDRESS (Street, city or town, state) <u>Dec 28, 59</u> | |
| PHYSICIAN'S NAME (Type) <u>Wilmer Bortner</u> | | DATE SIGNED <u>Dec 28, 59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>12/31/59</u> | <u>Wiseburg Cemetery</u> | <u>Parkton, Md. R.D.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Bortner</u> | | 24a. REC'D BY REGISTRAR <u>DEC 31 '59</u> | |
| ADDRESS <u>New Freedom, Pa.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

1935

STATE OF TEXAS

1935

1

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1



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13336

13360

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Penn.</u> b. COUNTY <u>Erie</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> | | c. LENGTH OF STAY IN 1b <u>75 x - 3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3306 Gwynndale Ave.</u> | | d. STREET ADDRESS <u>956 Brown's Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Ebba C. Carlson</u> | | 4. DATE OF DEATH <u>Dec. 13 1959</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 21, 1881</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Sweden</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>August Hanson</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Matilda Hanson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Miss Louise Carlson - 5306 Gwynndale Ave</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma sigmoid</u>
<u>1533</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1949</u> 19 to <u>1959</u> , that I last saw the deceased alive on <u>Sept</u> 1959, and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H.V. Harper</u> | | DATE SIGNED <u>Dec 13 1959</u> | |
| PHYSICIAN'S NAME (Type) <u>H.V. HARPER</u> | | ADDRESS (Street, city or town, State) <u>5201 Leverage Ave Balto Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12/17/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ERIE CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>ERIE PENNSYLVANIA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u> | | ADDRESS <u>6411 Windsor M. H. Rd.</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 15 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u> | |

CERTIFICATE OF DEATH

13860

RECEIVED
JAN 10 1960
MAY 10 1960
JUN 10 1960
JUL 10 1960
AUG 10 1960
SEP 10 1960
OCT 10 1960
NOV 10 1960
DEC 10 1960

| | |
|------------------------|--|
| NAME OF DECEASED | |
| AGE | |
| SEX | |
| RACE | |
| DATE OF BIRTH | |
| PLACE OF BIRTH | |
| CITY | |
| STATE | |
| COUNTRY | |
| DATE OF DEATH | |
| PLACE OF DEATH | |
| CITY | |
| STATE | |
| COUNTRY | |
| CAUSE OF DEATH | |
| MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | |
| SIGNATURE OF REGISTRAR | |
| DATE OF REGISTRATION | |
| PLACE OF REGISTRATION | |
| CITY | |
| STATE | |
| COUNTRY | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13361

CERTIFICATE OF DEATH

Reg. Dist. No.

13357

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Summit Nursing Home-98 Smithwood Ave. | | | | x
d. STREET ADDRESS
5604 Gwynn Oak Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle J. Last CARRICK | | 4. DATE OF DEATH
Month Dec. Day 15, Year 1959 | | | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 31, 1884 | 9. AGE (In years lost birthday)
75 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
214-12-4630 | | INFORMANT Address
Mrs. Pauline Collins - 5604 Gwynn Oak Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 Congestive Heart Failure
DUE TO (b) Acute & chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Heart Disease Degenerative Type
DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 59 to 12/15/59 , that I last saw the deceased alive on 12/14/59 and that death occurred at 1255 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
W. E. McGrath | | M.D. | | ADDRESS (Street, city or town, state)
1303 Frederick Rd Catonsville 28 Md | | DATE SIGNED
12/15/59 | |
| PHYSICIAN'S NAME (Type)
W. E. McGrath | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/18/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Western Cem. | | 22d. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Dickner & Sons - Balto, Md | | | | 24a. REC'D BY REGISTRAR
DATE DEC 16 '59 | | 24b. REGISTRAR'S SIGNATURE
Charles S. Kraus | |

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CERTIFICATE OF DEATH

13361



[Faint, mostly illegible text and lines forming a form structure, likely containing fields for name, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13362

CERTIFICATE OF DEATH

13338

Reg. Dist. No.

32

| | | | |
|---|------------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY TALBOT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson | | c. LENGTH OF STAY IN 1b
2040-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) RUSSELL LEE CARTER | | 4. DATE OF DEATH 12 - 11 - 1959 | |
| 5. SEX
MALE | 6. COLOR OR RACE
COLORED | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-12-29 |
| 9. AGE (In years last birthday) 30 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
UPHOLSTER | | 10b. KIND OF BUSINESS OR INDUSTRY
UPHOLSTERING | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
JAMES CARTER | | 14. MOTHER'S MAIDEN NAME
MINNIE SIFT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO.
218-20-8492 | |
| 17. INFORMANT
Hospital Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 521X ABSCESS OF LUNG
DUE TO (b) 7 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Meningitis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from 12-4- , 19 59 , to 12-11- , 19 59 , that I last saw the deceased alive on 12-10- , 19 59 , and that death occurred at 5 A.M. , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE William Newcomer | | ADDRESS (Street, city or town, state) Mt. Wilson, Maryland | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | DATE SIGNED 12-11-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 16 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Family Brown | | 22d. LOCATION (City, town, or county) (State) Easton | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.B. Johnson | | ADDRESS Annapolis Md | |
| 24a. REC'D BY REGISTRAR DEC 15 '59 | | 24b. REGISTRAR'S SIGNATURE William S. Adams | |

13363

CERTIFICATE OF DEATH

Reg. Dist. No.

13339

| | | | | | |
|---|---|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY a.a. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | c. LENGTH OF STAY IN 1b
2 days | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | d. STREET ADDRESS
315 Orchard Avenue | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First HUGH Middle O. Last CARY | | | 4. DATE OF DEATH
Month December Day 31 Year 19 59 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 31, 1908 | | 9. AGE (In years lost birthday)
51 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Assistant Manager | | 10b. KIND OF BUSINESS OR INDUSTRY
Super Market | 11. BIRTHPLACE (State or foreign country)
Alexandria, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Edward L. Cary | | | 14. MOTHER'S MAIDEN NAME
Mary Cary | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW II | | 16. SOCIAL SECURITY NO.
577-09-6736 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE HEMORRHAGIC PANCREATITIS
587.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SHOCK
(c) EDEMA OF THE LUNGS | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN
UNKNOWN | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from December 29, 1959 , to December 31, 1959 , that I last saw the deceased alive on December 29, 1959 , and that death occurred at 1:20 PM , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
Daniel A. Nieves | | ADDRESS (Street, city or town, state)
VAH, BALTO. MD. FT HOWARD DIV | | DATE SIGNED
1/1/60 | |
| PHYSICIAN'S NAME (Type)
DANIEL A. NIEVES | | VAH, BALTO. MD. FT HOWARD DIV. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
1-5-60 | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm Cook Blight Funeral Home, | | ADDRESS
6009 Harford Rd. | | 24a. REC'D BY REGISTRAR
DATE JAN 5 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |
| | | Balto. Md. | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1384

25-215

100

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13374

CERTIFICATE OF DEATH

Reg. Dist. No.

13340

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
57 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle L. Last CHARVAT | | 4. DATE OF DEATH
Month DECEMBER Day 12 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/27/11 |
| 9. AGE (In years last birthday)
48 yrs. | | 10. IF UNDER 1 YEAR
Months 4 Days 18 Hours 15 Min. | 11. IF UNDER 24 HRS.
Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Off Set Pressman | | 10b. KIND OF BUSINESS OR INDUSTRY
Lithographing Co. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John J. Charvat | | 14. MOTHER'S MAIDEN NAME
Catherine Duval | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
212-01-2549 | |
| 17. INFORMANT
Clin. Rec. VAH, Balto., Md. Fort Howard Division | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA PANCREAS WITH METASTASIS TO STOMACH, ADRENALS, SPINE AND LIVER
157X
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.
(b) DUE TO
(c) MURAL THROMBUS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH MYOCARDIAL INFARCTION AND/
INTERVAL BETWEEN ONSET AND DEATH
2 MONTHS | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 16, 1959 to December 12, 1959 , that I last saw the deceased alive on December 12, 1959 and that death occurred at 11:55 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) VAH, BALTO., MD. FORT HOWARD DIVISION
DATE SIGNED 12/13/59 | | | |
| ACTUAL SIGNATURE Dr. T.R. Hood | | M.D. VAH, BALTO., MD. FORT HOWARD DIVISION | |
| PHYSICIAN'S NAME (Type) T.R. HOOD, M.D. | | VAH, BALTO., MD. FORT HOWARD DIVISION | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-17-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc. | | 24a. REC'D BY REGISTRAR
DEC 16 '59
DATE | |
| ADDRESS
6009 Harford Road
Baltimore, Maryland | | 24b. REGISTRAR'S SIGNATURE
Charles S. Hays | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1337

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1337

Blank form with faint lines for text entry, including fields for name, date, and location.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G253 12-28-59 et

13364

CERTIFICATE OF DEATH

Reg. Dist. No.

13341

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto (34)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9009 Simms</u> | | d. STREET ADDRESS <u>9009 Simms Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John George</u> First <u>CHENOWETH</u> Middle <u>Lost</u> | | 4. DATE OF DEATH <u>Dec</u> Month <u>16</u> Day <u>19</u> Year <u>59</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 18, 1872</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home Bldg.</u> | |
| 11. BIRTH PLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>ASBURY CHENOWETH</u> | | 14. MOTHER'S MAIDEN NAME <u>JANE SANDERSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>LESTER CHENOWETH</u> Address <u>2820 CHENOWETH AVE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion & Infarction</u>
<u>420.1</u> DUE TO <u>Atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Age</u>
(c) <u>Age</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
<u>5-10 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Infarction (Convalescence)</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u>Jan</u> Day <u>19</u> Year <u>1959</u>
Hour <u>6:30</u> a. m. <u>pm.</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>Dec 1959</u> that I last saw the deceased alive on <u>12/19/59</u> and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u> M.D. <u>9005 Harford Rd</u> | | DATE SIGNED <u>12/16/59</u> | |
| PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR.</u> | | <u>BALTO 14 Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>DEC 19, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>HISS CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MARYLAND</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Road #6.</u> ADDRESS <u>#6.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 21 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

CERTIFICATE OF DEATH

13584

| | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|--------------------------|--|--------------------|--|------------------------|--|--------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES C. HARRIS | | M | | 45 | | JAN 15 1890 | | BALTIMORE | | MD | | USA | | USA | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | PREVIOUS ILLNESS | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | CITY | |
| Carpenter | | High School | | Married | | None | | Heart Disease | | Natural | | Home | | BALTIMORE | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR | | MINUTE | | SECOND | | DAY | | MONTH | | YEAR | |
| JAN 20 1935 | | 10:30 AM | | 10 | | 30 | | 00 | | JAN | | 1935 | | 1935 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | | SIGNATURE OF JUDGE | | SIGNATURE OF SHERIFF | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 20 1935 | | JAN 20 1935 | | JAN 20 1935 | | JAN 20 1935 | | JAN 20 1935 | | JAN 20 1935 | | JAN 20 1935 | | JAN 20 1935 | |

RECEIVED
JAN 21 1935

RECEIVED
JAN 21 1935

13365

CERTIFICATE OF DEATH

13342

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i> | | d. STREET ADDRESS <i>822 E. Belvedere Ave.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>(Mollie) Mary</i> First <i>E.</i> Middle <i>Clark</i> Last | | 4. DATE OF DEATH Month <i>Dec.</i> Day <i>14</i> Year <i>1959</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12-29-1891</i> |
| 9. AGE (In years last birthday) <i>68</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Joseph O'Brien</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Hopper</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>same</i> | |
| 16. SOCIAL SECURITY NO. <i>Willard R. Clark</i> | | 17. INFORMANT Address <i>same</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>carcinomatosis</i>
DUE TO <i>Adenocarcinoma of stomach (removed Nov. 5, 1958)</i>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>151x</i>
(c) <i>12yr</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>12yr</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Oct '54</i> 19 <i>Dec 14</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 12</i> , 19 <i>59</i> , and that death occurred at <i>8:20 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Fredrick J. Vollmer</i> M.D. | | ADDRESS (Street, city or town, state) <i>6100 York Rd Balto + 2 Md</i> DATE SIGNED <i>12/15/59</i> | |
| PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE THEREOF <i>12-17-59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd</i> | | 24a. REC'D BY REGISTRAR DATE <i>DEC 17 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13362

Dec. 1911

Baltimore

Baltimore

Female

612 S. Calverton Ave.

John H. Calverton

Dec.

1911

(Date of Death)

62

12-21-11

White

MD

Highland

Highland

Proper

John H. Calverton

John H. Calverton

John H. Calverton

(The deceased was a resident of Baltimore, Md., at the time of death.)

(Signature)

Baltimore, Md.

John H. Calverton

12-21-11

Female

John H. Calverton, M.D.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13366

Items 4. & 22, 12/17/59-mnb Phone Call

CERTIFICATE OF DEATH

Reg. Dist. No.

13343

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
26r 7mth2ldys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Clayton Last Clayton | | 4. DATE OF DEATH
Month December Day 12 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> Sep DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 17, 1865 |
| 9. AGE (In years lost birthday)
94 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John F. Clayton | | 14. MOTHER'S MAIDEN NAME
Sarah DeMoss | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerotic Cardiovascular Disease
(c) Atherosclerotic Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 11 , 19 59 , to Dec. 12 , 19 59 , that I last saw the deceased alive on Dec. 11 , 19 59 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED
ACTUAL SIGNATURE Edward T. Schmitt M.D.
PHYSICIAN'S NAME (Type) Catonsville 26, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/14/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Fork Methodist Cemetery | | 22d. LOCATION (City, town, or county) (State)
Fork, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lassahn Funeral Home | | 24a. REC'D BY REGISTRAR
Baltimore 6, Md. | |
| 24b. REGISTRAR'S SIGNATURE | | DATE | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13367

CERTIFICATE OF DEATH

Reg. Dist. No. 13344

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2713 Waldor Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John Bramble Cole</u> | | 4. DATE OF DEATH <u>Dec. 3 19 59</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-3-1880</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William G. Cole</u> | | 14. MOTHER'S MAIDEN NAME <u>Wilhelmina Bramble</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u>215-03-3209</u> | |
| 17. INFORMANT <u>Winifred Truffer</u> | | Address <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u> </u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u> |
| 21. I certify that I attended the deceased from <u>24 June</u> , 19 <u>56</u> , to <u>3 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 Dec</u> , 19 <u>59</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u> | | | |
| ACTUAL SIGNATURE <u>Harold Goodman</u> M.D. <u> </u> | | | |
| PHYSICIAN'S NAME (Type) <u> </u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 22b. DATE THEREOF <u>12-7-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> | | 24a. REC'D BY REGISTRAR <u>DEC 7 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1386

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13368
CERTIFICATE OF DEATH

13345

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
3yr10mth8 dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS
3112 Parkway Terrace | |
| 3. NAME OF DECEASED (Type or print)
First Nellie Middle Nancy Last Colegrove | | 4. DATE OF DEATH
Month DEC. Day 27 Year 1959 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 20, 1866 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
schoolteacher | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
93 yrs. |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Orrin C. Bromwell | | 14. MOTHER'S MAIDEN NAME
Rebecca Gilman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL DEBILITY
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JULY 1 , 19 59 , to DEC 27 , 19 59 , that I last saw the deceased alive on Dec. 27 , 19 59 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED
ACTUAL SIGNATURE P. K. Yip M.D.
PHYSICIAN'S NAME (Type) P. K. Yip M.D. Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/31/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Pine Grove Crm., Pa | | 22d. LOCATION (City, town, or county) (State)
Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Maenah + Son Balt 28
BRACKEN FUNERAL HOME | | 24a. REC'D BY REGISTRAR
DEC 29 1959 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Prans | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13368

18345

| | | | |
|-------------------------------|--|-------------------------------|--|
| <p>NAME OF DECEASED</p> | | <p>DATE OF DEATH</p> | |
| <p>AGE</p> | | <p>SEX</p> | |
| <p>PLACE OF BIRTH</p> | | <p>DATE OF BIRTH</p> | |
| <p>EDUCATION</p> | | <p>OCCUPATION</p> | |
| <p>CAUSE OF DEATH</p> | | <p>IMMEDIATE CAUSE</p> | |
| <p>UNDERLYING CAUSE</p> | | <p>PERMANENT CAUSE</p> | |
| <p>DATE OF EXAMINATION</p> | | <p>PLACE OF EXAMINATION</p> | |
| <p>SIGNATURE OF PHYSICIAN</p> | | <p>SIGNATURE OF REGISTRAR</p> | |
| <p>DATE OF SIGNATURE</p> | | <p>DATE OF SIGNATURE</p> | |

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 3Vo1-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | d. STREET ADDRESS
1208 McElderry Court | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
FRANK | | First
I. | | Middle
J. | | Last
COLLETT | |
| 4. DATE OF DEATH
December 6 19 59 | | Month
December | | Day
6 | | Year
19 59 | |
| 5. SEX
Male | | 6. COLOR OR RACE
colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 29, 1918 | |
| 9. AGE (In years last birthday)
41 yrs. | | IF UNDER 1 YEAR
Months
4 | | IF UNDER 24 HRS.
Days
4 | | Hours
4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BARBER | | 10b. KIND OF BUSINESS OR INDUSTRY
Barber Shop | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Herbert Collett | | | | 14. MOTHER'S MAIDEN NAME
Rebecca Pratt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
II | | INFORMANT
Clin. Rec. Vet. Adm. Hospital Balto 18, Md Ft. Howard | | Address
Division | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EDEMA LUNGS
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.
(b) HEMORRHAGE RIGHT FRONTAL LOBE
DUE TO
(c) UNKNOWN | | INTERVAL BETWEEN ONSET AND DEATH
HOURS | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
EMPHYSEMATOUS BLEBS BOTH LUNGS | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 23, 19 59 to December 6, 19 59 and that death occurred at 1:00 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
John W. Crawford | | ADDRESS (Street, city or town, state)
VAH BALTO 18, MD FT HOWARD DIV | | DATE SIGNED
12/7/59 | | | |
| PHYSICIAN'S NAME (Type)
JOHN W. CRAWFORD, M.D. | | M.D.
VAH Balto 18, Md. Ft Howard Div. | | 12/7/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-10-1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arlington S. Phillips | | ADDRESS
1808 N Monroe St Baltol7, Md | | 24a. REC'D BY REGISTRAR
DEC 14 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

13362

CERTIFICATE OF DEATH

13362

[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]

STATE OF NEW YORK
COUNTY OF ...
I, the undersigned, a Justice of the Peace in and for the County of ... do hereby certify that on the ... day of ... 19... at ... in the County of ... the body of ... deceased ...
Witness my hand and the seal of said County at ... this ... day of ... 19...

Justice of the Peace
Notary Public
City of New York

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13370

CERTIFICATE OF DEATH

14353

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Woodlawn | | c. LENGTH OF STAY IN 1b
15 Yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Dogwood Road(Quaker Hill) | | e. STREET ADDRESS
Dogwood Road (Quaker Hill) | |
| 3. NAME OF DECEASED (Type or print)
First Anna Middle G. Last Crawford | | 4. DATE OF DEATH
Month 12 Day 29 Year 19 59 | |
| 5. SEX
F. | 6. COLOR OR RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED | 8. DATE OF BIRTH
Feb. 18, 1885 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Dietrich Albers | | 14. MOTHER'S MAIDEN NAME
Helena Kuhlman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-01-7677 B. | |
| 17. INFORMANT
Mr. Karl W. Schaper | | Address Quaker Hill Dogwood Road, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident -
443X DUE TO Hypertensive C.V. disease - severe -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 day
(c) 15 years | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan 6 , 19 55 , to Dec 29 , 19 59 , that I last saw the deceased alive on Dec 29 , 19 59 , and that death occurred at 11 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Thomas E. Wheeler | | ADDRESS (Street, city or town, state)
3601 Chapman Rd - 7 - | |
| PHYSICIAN'S NAME (Type)
THOS. E. WHEELER | | DATE SIGNED
12/30/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Jan. 1, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Taylorville Cemetery | | 22d. LOCATION (City, town, or county) (State)
Taylorville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
LORING BYERS | | 24a. REC'D BY REGISTRAR
DATE JAN 7 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kiana | | 24c. ADDRESS
8728 Liberty Road Randallstown, Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13370

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible] MARRIED: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] CAUSE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible] NAME OF FUNERAL HOME: [illegible]

DATE OF REGISTRATION: [illegible] NAME OF REGISTRAR: [illegible] SIGNATURE: [illegible]

DATE OF REVIEW: [illegible] NAME OF REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

DATE OF FINAL REVIEW: [illegible] NAME OF FINAL REVIEWER: [illegible] SIGNATURE: [illegible]

CERTIFICATE OF DEATH

13347

Reg. Dist. No.

| | | | |
|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PARKVILLE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3346 W. Loughby Rd</u> | | d. STREET ADDRESS <u>3346 W. Loughby Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>John</u> Middle <u>CROSS</u> Last <u>SR</u> | | 4. DATE OF DEATH <u>Dec</u> Month <u>7</u> Day <u>1959</u> Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>X</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 10, 1908</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CHAS. L. CROSS</u> | | 14. MOTHER'S MAIDEN NAME <u>MARGARET LINDNER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>22-16-3799</u> | |
| 17. INFORMANT <u>Mamie V CROSS</u> | | Address <u>5141 C</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 5th</u> , 19 <u>59</u> , to <u>Dec 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P. M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James E. White</u> | | ADDRESS (Street, city or town, state) <u>5214 Harford Rd, Balto.</u> DATE SIGNED <u>Dec 8/59</u> | |
| PHYSICIAN'S NAME (Type) <u>James E. White M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>Dec 11, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u> | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F Evans & Son</u> | | ADDRESS <u>8802 Harford Rd</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 11 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13372
CERTIFICATE OF DEATH

13348

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | | c. LENGTH OF STAY IN 1b
<u>60 years</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X LUTHERVILLE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>305 Melancton Ave.</u> | | | | d. STREET ADDRESS
<u>305 MELANCTON AVE</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
<u>GWYNN</u> | | First Middle Last
<u>CROWTHER</u> | | 4. DATE OF DEATH
Month <u>DEC.</u> Day <u>20</u> Year <u>1959</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>MAY 28, 1882</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RET. BANKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>FINANCIAL</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>JOHN CROWTHER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>WORTHENA HISS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216-14-1065A</u> | | 17. INFORMANT
<u>G. KENNETH CROWTHER</u> | | Address
<u>ABOVE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
<u>181.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic transitional cell carcinoma, bladder</u>
DUE TO (c) <u>transitional cell carcinoma, bladder</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>5 months</u>
<u>20 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>phoric laminitis for root nerve pain Sept. 1958</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 18</u> , 19 <u>59</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John B. Crowther</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>M.D. 1707 Notre Dame Ave, Lutherville MD 12-20-59</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>12-22-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>DRUID RIDGE</u> | | 22d. LOCATION (City, town, or county) (State)
<u>PIKESVILLE MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>H.W. JENKINS & Sons Co.</u> | | | | ADDRESS
<u>4905 YORK RD, BALTO</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 21 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanes</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---------------------------------------|--|--|--|---|--|---|--|--|--|
| NAME OF DECEASED
<i>John Williams</i> | | AGE
<i>45</i> | | SEX
<i>Male</i> | | RACE
<i>White</i> | | DATE OF DEATH
<i>Jan 15 1918</i> | | PLACE OF DEATH
<i>Home</i> | |
| BIRTH
<i>Jan 15 1873</i> | | DEATH
<i>Jan 15 1918</i> | | CAUSE OF DEATH
<i>Heart Disease</i> | | MANNER OF DEATH
<i>Natural</i> | | DURATION OF ILLNESS
<i>2 weeks</i> | | PREVIOUS ILLNESS
<i>None</i> | |
| FATHER'S NAME
<i>John Williams</i> | | MOTHER'S NAME
<i>Mary Williams</i> | | BIRTHPLACE
<i>Maryland</i> | | RESIDENCE
<i>123 Main St Baltimore</i> | | OCCUPATION
<i>Teacher</i> | | EDUCATION
<i>High School</i> | |
| MARITAL STATUS
<i>Married</i> | | SPOUSE'S NAME
<i>Mary Williams</i> | | SPOUSE'S BIRTH
<i>Jan 15 1873</i> | | SPOUSE'S DEATH
<i>Jan 15 1918</i> | | SPOUSE'S CAUSE OF DEATH
<i>Heart Disease</i> | | SPOUSE'S MANNER OF DEATH
<i>Natural</i> | |
| PREVIOUS ILLNESS
<i>None</i> | | DURATION OF ILLNESS
<i>2 weeks</i> | | MANNER OF DEATH
<i>Natural</i> | | CAUSE OF DEATH
<i>Heart Disease</i> | | PLACE OF DEATH
<i>Home</i> | | DATE OF DEATH
<i>Jan 15 1918</i> | |

1

OFFICE OF THE REGISTRAR

THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, HAS RECEIVED THE ABOVE CERTIFICATE OF DEATH, AND THE SAME IS HEREBY FILED FOR THE PURPOSE OF RECORDING THE SAME.

WITNESSETH MY HAND AND SEAL OF OFFICE, THIS 15th DAY OF JANUARY, 1918.

REGISTRAR

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-4-60 et

13373

CERTIFICATE OF DEATH

Reg. Dist. No.

13349

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upperco</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upperco</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Benson Mill Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Annie</u> Middle <u>R.</u> Last <u>Curtis</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>25</u> Year <u>19 59</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 1, 1874</u> |
| 9. AGE (In years last birthday)
<u>85 1/2</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Bruehl</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rebecca Ryan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Mrs. Ernest Hale</u> | | Address
<u>Upperco, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.
(b) <u>Hypertensive C-V Disease</u> DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 da</u>
<u>19 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes 14 yrs.</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>none</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>none</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>none</u> p. m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
<u>none</u> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>none</u> | | 20f. (City or town) (County) (State)
<u> </u> <u> </u> <u> </u> | |
| 21. I certify that I attended the deceased from <u>4-19, 1940</u> , to <u>12-25, 1959</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>59</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>D. D. Caples</u> | | ADDRESS (Street, city or town, state)
<u>6 Hanover Rd.</u> | |
| PHYSICIAN'S NAME (Type)
<u>D. D. CAPLES, M.D.</u> | | DATE SIGNED
<u>Reisterstown, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Dec. 28, 1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Black Rock Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Butler Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Edward C. Tipton</u> | | ADDRESS
<u>Hampstead, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>DEC 29 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Evans</u> | |

OFFICIAL RECORD

CERTIFICATE OF DEATH

1933

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13375
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balt.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Ind.</u> b. COUNTY <u>Balt.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Reisterstown</u> | c. LENGTH OF STAY IN 1b
<u>1 yr</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Reisterstown, Ind.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>219 Lenwood Ave</u> | | d. STREET ADDRESS
<u>219 Lenwood Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>EDNA</u> First Middle Last | | 4. DATE OF DEATH
Month <u>Dec</u> Day <u>31</u> Year <u>1959</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Mar 11, 1889</u> |
| 9. AGE (in years last birthday)
<u>70</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Insurance</u> | 11. BIRTHPLACE (State or foreign country)
<u>Balt. Ind.</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>W.S.A.</u> | | 13. FATHER'S NAME
<u>Bradley A. Davison</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Katharin Monath</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)
<u>No.</u> | |
| 16. SOCIAL SECURITY NO.
<u>Ind.</u> | | 17. INFORMANT
<u>Henrietta Bottiger</u> Address <u>219 Lenwood Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u>
<u>500X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Acute Bronchitis.</u>
(c) <u>None</u>
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 hrs.</u>
<u>4 days</u> |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
<u>None</u> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>None</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>None</u> | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>D. D. Caples</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>D. D. CAPLES, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>1-2-1960</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>oak lawn</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTIMORE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Luck</u> | | ADDRESS
<u>5305 Hayford</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>JAN 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | |

DATE SIGNED

12-31-59

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13375

13351

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|----------------------------------|--|---|--|---|--|---|--|--|--|--|--|------------------------|--|-----------------------|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rosedale
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
6600 Block Pulaski Highway | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
3717 Belair Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
ANTONIO (ANTHONY) Di GUARDO | | 4. DATE OF DEATH
Month
December
Day
5
Year
19 59 | | 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 11, 1882 | | 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YEAR
Months
77 | | 11. IF UNDER 24 HRS.
Days
77 | | 12. Hours
77 | | 13. Min.
77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Gardener | | | | 10b. KIND OF BUSINESS OR INDUSTRY
self-employed | | | | 11. BIRTHPLACE (State or foreign country)
Italy | | | | 12. CITIZEN OF WHAT COUNTRY?
Italy | | | | | | | | | |
| 13. FATHER'S NAME
Salvatore DiGuardo | | | | 14. MOTHER'S MAIDEN NAME
Ida Calvonara | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
none | | | | 17. INFORMANT
Salvatore DiGuardo, son, 3124 Kentucky Ave | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease.
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Petty | | | | EXAMINER'S NAME (Type)
Charles S. Petty, M.D. | | | | M.D.
Charles S. Petty | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED
12/8/59 | | | | Address (Street, city, town, or county) | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Entombment | | | | 22b. DATE THEREOF
12/10/59 | | | | 22c. NAME OF CEMETERY OR CREMATORY
Lorraine Mausoleum | | | | 22d. LOCATION (City, town, or country) (State)
Baltimore, Md. | | | | | | | | | |
| 23. FUNERAL DIRECTOR
Charles E. Schimunek Funeral Home
3331 Brehms Lane | | | | | | | | 24a. REC'D BY REGISTRAR
DEC 9 '59 | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14354

14378

CERTIFICATE OF DEATH

Reg. Dist. No.

32

| | | | | | |
|---|----------------------------------|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Pr. George ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson, Maryland | | c. LENGTH OF STAY IN 1b
219 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Beltsville 16 74-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | d. STREET ADDRESS
Ammendale Normal Institute | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Walter First Michael Middle Doczkowski Last (Brother Fidelis Julian) | | 4. DATE OF DEATH
Month Dec. Day 30 Year 1959 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/18/1884 | 9. AGE (In years last birthday)
75 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Brother | | 10b. KIND OF BUSINESS OR INDUSTRY
Ammendale Normal Inst. | | 11. BIRTHPLACE (State or foreign country)
Lithuania | |
| 13. FATHER'S NAME
Viecent Dyczkowski | | 14. MOTHER'S MAIDEN NAME
Anna Prejsksza | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor pulmonale
002X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmanary tuberculosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
5 days | | 3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from May 25 , 19 59 , to Dec 30 , 19 59 , that I last saw the deceased alive on Dec 30 , 19 59 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 12/30/1959
ACTUAL SIGNATURE William Newcomer, M.D.
PHYSICIAN'S NAME (Type) Superintendent | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/4/1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Private Cemetery Ammendale Normal Institute, Ammendale, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Company, Riverdale, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE JAN 7 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13377

CERTIFICATE OF DEATH

Reg. Dist. No.

13352

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Buffalo Run Rd</u> | | d. STREET ADDRESS <u>Buffalo Run Rd</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Catherine</u> Last <u>Dolly</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>22 October 1917</u> |
| 9. AGE (In years last birthday) <u>42</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Oldfields, West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Aaron Blaine Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Bessie Alma Kessel</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-22-9635</u> | |
| 17. INFORMANT <u>Husband Mason Dolly</u> Address <u>Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of lung</u>
<u>163X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>28 Dec</u> , 19 <u>59</u> , to <u>29 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Walter T. Kees</u> | | ADDRESS (Street, city or town, state) <u>Cockeysville, Md</u> DATE SIGNED <u>29 December 1959</u> | |
| PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-2-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Dolly Family Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Old Field, West Virg.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson 4, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JAN 4 1960</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | | | |

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13378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13353

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN 1b
3 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First FRANK Middle J. Last DORAN | | | | 4. DATE OF DEATH
Month December Day 8 Year 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
October 8, 1893 | |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. | | 11. BIRTHPLACE (State or foreign country)
Chester, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sawman | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Company | | | |
| 13. FATHER'S NAME
Daniel Doran | | | | 14. MOTHER'S MAIDEN NAME
Clara Banks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
213-07-7622 | | | |
| 17. INFORMANT
Clin. Rec., Vet. Adm. Hosp. Balto. 18, Md. Ft. Howard | | | | Address
Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EDEMA OF LUNGS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARDIAC DECOMPENSATION
(c) CARDIAC HYPERTROPHY, MITRAL INSUFFICIENCY AND DILATATION | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH
Less than 1 day | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 5, 1959 to December 8, 1959 that I last saw the deceased alive on December 8, 1959 and that death occurred at 6:55 AM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
John W. Crawford | | | | ADDRESS (Street, city or town, state)
M.D. VAH, FT. HOWARD DIVISION BALTO. 18, MD 12/8/59 | | | |
| PHYSICIAN'S NAME (Type)
JOHN W. CRAWFORD, M.D. | | | | DATE SIGNED
VAH, BALTO 18, MD. FORT HOWARD DIVISION 12/8/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
12-11-59 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Duda Funeral Home 7922 Wise Ave. Balto. Md | | | | 24a. REC'D BY REGISTRAR
DEC 11 '59 | | | |
| 24b. REGISTRAR'S SIGNATURE
Anthony L. Kline | | | | | | | |

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

11

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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|---|--|---|--|---|--|--|--|---|--|--|--|
| Items 20-21 Film 254-1 22-60-ams | | | | | | | | | | | |
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 13379 13354 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | | | c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3710 Milford Mill Road | | | | | | d. STREET ADDRESS 3716 Milford Mill Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LANCE | | | | | | 4. DATE OF DEATH DOSTER | | Month December | | Day 9, Year 1959 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 9, 1945 | | 9. AGE (In years last birthday) 14 yrs. | | IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY School | | 11. BIRTHPLACE (State or foreign country) Balt. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Robert L. Doster | | | | | | 14. MOTHER'S MAIDEN NAME Vera M. Brushwood | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mr. Robert L. Doster | | Address 3410 Croydon K. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive hemorrhage due to gunshot wound of left chest | | | | | | | | | | | |
| 919.0 INDEX | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Accidentally shot by friend | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
6:25 p.m. 12 9 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Pikesville | | (County) Baltimore | | (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | | | | | DATE SIGNED 12/10/59 | | | | | |
| Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 22d. LOCATION (City, town, or country) Balt. | | (State) Md. | | | |
| 23. FUNERAL DIRECTOR Loring Byers 8728 Liberty Road Randallstown, Md | | | | | | 24a. REC'D BY REGISTRAR DEC 17 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

RECEIVED STATE DEPARTMENT OF HEALTH
DIVISION OF BIRTH, DEATH AND MARRIAGE REGISTRATION
1937

1937

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Blank form with faint lines and text, likely a certificate or record.

1937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13380

CERTIFICATE OF DEATH

Reg. Dist. No.

13355

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7108 Bellona Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First DONALD Middle HERBERT Last ENGLER | | | | 4. DATE OF DEATH
Month Dec. Day 27 Year 19 59 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 18, 1903 | | 9. AGE (In years last birthday) yrs. 56 | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Atty. & Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. F. & G. | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Emory E. Engler | | | | 14. MOTHER'S MAIDEN NAME
Flora Jane Bailey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
215-07-8736 | | INFORMANT Address
Mrs. Kathareen Engler - 7108 Bellona Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Arteriosclerosis (cardiovascular disease)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c) thrombosis
INTERVAL BETWEEN ONSET AND DEATH
just men
4 yrs. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 57 , to Dec 27 , 19 59 , that I last saw the deceased alive on Dec 25/59 , 19 59 , and that death occurred at 8 a.m. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles Tubitt | | | | ADDRESS (Street, city or town, state) DATE SIGNED
4408 Oak Raven Blvd. | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/30/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Dickener & Sons - Balto | | | | 24a. REC'D BY REGISTRAR
DEC 28 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13880

13880

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13381

CERTIFICATE OF DEATH

13356

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u></u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> | | c. LENGTH OF STAY IN lb <u>5 mos.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Aged Mens & Womens Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Leland Evans</u> | | 4. DATE OF DEATH <u>December 8</u> 19 <u>59</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 11, 1867</u> |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>27</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hoopers Island, Dorchester Co. Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>F. B. Leland</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Barclay</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Daisy E. Hamilton, 615 Chestnut Ave</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebral Renal Vascular Disease</u>
<u>446x</u> DUE TO (b) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1954</u> to <u>December 8, 1959</u> , that I last saw the deceased alive on <u>December 6, 1959</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Newland Edwards Day</u> M.D. | | ADDRESS (Street, city or town, state) <u>4-2-33rd St - Balto</u> | |
| PHYSICIAN'S NAME (Type) <u>Newland Edwards DAY MD</u> | | DATE SIGNED <u>Dec 8, 1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-11-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> | | ADDRESS <u></u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 10 1959</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knap</u> | |

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1935

CERTIFICATE OF DEATH

1935

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12-11-35

1935

CERTIFICATE OF DEATH

Reg. Dist. No.

13357

13382

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|---|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Md.
b. COUNTY
Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Balto. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
House in the Pines
16 Fusting Ave | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Elizabeth Feher | | 4. DATE OF DEATH
Month Day Year
Dec. 3, 19 59 | |
| 5. SEX
F. | 6. COLOR OR RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 29, 1880 |
| 9. AGE (In years last birthday)
79 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Hungary | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Novak | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
[If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO.
Mr. John F. Feher, 10 Overhill Rd, Catns 28 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Decomensation
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Hypertensive Cardio-Vascular Disease
DUE TO
(c) 15 yr. | | INTERVAL BETWEEN ONSET AND DEATH
1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-17-1958 to 12-3-1959 , that I last saw the deceased alive on 12-2-1959 , and that death occurred at 12-3-1959 , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wilmer K. Gallagher | | ADDRESS (Street, city or town, state) 6209 Frederick Road Catonsville 28, Md. | |
| PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D. | | DATE SIGNED 12-3-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/5/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Louden Park Cemtry | | 22d. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Witzke Funeral Dir. 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR
DATE DEC 4 '59 | |
| 24b. REGISTRAR'S SIGNATURE
James S. Thomas | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF OHIO

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13358

13383

FOR STATE
HEALTH DEPT.

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|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Brooklandville | | c. LENGTH OF STAY IN lb
student | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Paul's School | | d. STREET ADDRESS
305 Greenwood Rd. | |
| 3. NAME OF DECEASED (Type or print)
Linda M. Finley | | 4. DATE OF DEATH
Month Dec. Day 7 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 25, 1947 |
| 9. AGE (in years last birthday)
12 yrs. | | 10. IF UNDER 1 YEAR
Months 12 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
student | | 10b. KIND OF BUSINESS OR INDUSTRY
student | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert M. Finley | | 14. MOTHER'S MAIDEN NAME
Nancy Griffith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Robert M. Finley | | Address
305 Greenwood Rd., Rux- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture base of skull with intercranial hemorrhage
9036 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) none
(c) none | | INTERVAL BETWEEN ONSET AND DEATH
15 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell on flagstone patio at school. | |
| 20c. TIME OF INJURY
Month, Day, Year
4 Hour XX p. m. Dec. 7 1959 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
School-St. Paul's-Brooklandville, Balto. | | 20f. (City or town) (County) (State)
Balto. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
D. D. Caples | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
D. D. Caples, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-9-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 22d. LOCATION (City, town, or county) (State)
Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H.W. Jenkins & Son, Co., 4905 York Rd, Balto | | 24a. REC'D BY REGISTRAR
DEC 9 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13359

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY BALTO MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MD. b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4 EASTERN AVE. | | d. STREET ADDRESS
1 139 RIVERSIDE RD. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First IDA Middle T Last FISCHER | | 4. DATE OF DEATH
Month DEC Day 25 Year 19 59 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 19-1877 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY
— | |
| 11. BIRTHPLACE (State or foreign country)
BALTO. | | 12. CITIZEN OF WHAT COUNTRY?
— | |
| 13. FATHER'S NAME
HUGH DEVINEY | | 14. MOTHER'S MAIDEN NAME
KITTEY SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
— | | 16. SOCIAL SECURITY NO.
— | |
| 17. INFORMANT
MYRTLE BUEDEL | | Address
SAME AS ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) A-S-C-V Disease
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Severe | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
BALTO. MD. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
M.B. Davis M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
M.B. Davis M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
12/29/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 22d. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Connelly | | ADDRESS
Essex 21 - Md. | |
| 24a. REC'D BY REGISTRAR
DEC 31 '59 | | 24b. REGISTRAR'S SIGNATURE
C. J. ... | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|------------------|--|-----|--|-----|--|------|--|----------|--|----------|--|-----------|--|------------|--|-----------|--|---------------|--|----------------|--|----------------|--|-----------------|--|-----------------------|--|------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | RESIDENCE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | | DATE | |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13385

CERTIFICATE OF DEATH

13360

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Balto.
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Md.
b. COUNTY
Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | | c. LENGTH OF STAY IN 1b
60 Yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
9119 Liberty Road | | e. IS RESIDENCE ON A FARM?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Kitty | | 4. DATE OF DEATH
Monday December 14, 1959 | |
| 5. SEX
F. | 6. COLOR OR RACE
W. | 7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 30, 1871 |
| 9. AGE (In years last birthday)
88 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
School | |
| 11. BIRTHPLACE (State or foreign country)
Hernwood, Balto. Co; | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Edward Fite | | 14. MOTHER'S MAIDEN NAME
Kate Mathews | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Edward F. Stanfield | | Address
9000 Church Road Randallstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion -
420.1
DUE TO Severe generalized arteriosclerosis -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. disease
(c) 15 years | | | INTERVAL BETWEEN ONSET AND DEATH
1 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 1, 1954 , to Dec. 14, 1959 , that I last saw the deceased alive on Dec. 14, 1959 , and that death occurred at 3 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Thomas E. Wheeler | | ADDRESS (Street, city or town, state) DATE SIGNED
3601 Clifmar Road, Balto. 7, Md. | |
| PHYSICIAN'S NAME (Type)
Dr. Thomas E. Wheeler | | 3601 Clifmar Road, Balto. 7, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-17-1959 | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Paran Church Cemetery | 22d. LOCATION (City, town, or county) (State)
Harrisonville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
LORING BYERS | | ADDRESS
8728 Liberty Road, Randallstown, Md. | |
| 24a. REC'D BY REGISTRAR
DATE
DEC 17 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Krane | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13300

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON - 10

CERTIFICATE OF DEATH

REG. NO.

13300

DATE

PLACE

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME

PLACE

DATE

PLACE OF DEATH

DATE

PLACE

DATE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13361

13386

| | | | | | | | |
|--|---|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>3v01-4</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>SPRING GROVE STATE HOSPITAL</u> | | | | d. STREET ADDRESS
<u>1814 Edmondson Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Anna</u> Middle <u>Pitzpatrick</u> Last <u>Pitzpatrick</u> | | | | 4. DATE OF DEATH
Month <u>DEC.</u> Day <u>10</u> Year <u>1959</u> | | | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 9, 1892</u> | 9. AGE (In years lost birthday)
<u>67</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>DOMESTIC</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Daniel Martynn</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Emma ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>unknown</u> <u>NONE</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
Address
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the bowel</u>
<u>153.9</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ascites</u>
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>NOV 10 - DEC 10</u>
<u>(one month)</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Arteriosclerotic heart disease</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>November 7, 1959</u> , to <u>December 10, 1959</u> , that I last saw the deceased alive on <u>December 10, 1959</u> , and that death occurred at <u>6</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Loretta Hsu</u> | | ADDRESS (Street, city or town, state)
<u>SPRING GROVE STATE HOSPITAL</u>
DATE SIGNED | | | | | |
| PHYSICIAN'S NAME (Type)
<u>Loretta Hsu, M.D.</u> | | <u>Catonsville 28, Maryland</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>12-12-59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>LONDON PARK</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MD</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Geo. J. Schwab Funeral Home</u>
<u>2 Francis W. Miller 2101 Fidelity Ave.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 14 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Evans</u> | |

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13387

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland
c. LENGTH OF STAY IN TB 1 1/2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12, Maryland
d. STREET ADDRESS 723 Radnor Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Daniel Middle Fleming Last Fleming | | 4. DATE OF DEATH
Month 12 Day 16 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/2/42 |
| 9. AGE (In years last birthday) 17 yrs. | | IF UNDER 1 YEAR
Months 17 Days 17 Hours 17 Min. | IF UNDER 24 HRS.
Months 17 Days 17 Hours 17 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Lonie Fleming | |
| 14. MOTHER'S MAIDEN NAME Lonie Little | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. no | | INFORMANT Rosewood Records Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pyelo-nephritis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b) Decubitus Ulcers
DUE TO
(c) Epilepsy | | | INTERVAL BETWEEN ONSET AND DEATH
7 months
1 1/2 years
16 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Organic brain damage - birth | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6/20/58 , 19____, to 12/16/59 , 19____, that I last saw the deceased alive on 12/16/59 , 19____, and that death occurred at 1:22p M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Ernest I. Decko | | ADDRESS (Street, city or town, state) Rosewood DATE SIGNED 12/18/59 | |
| PHYSICIAN'S NAME (Type) Ernest I. Decko, M.D. | | Rosewood Tr. School, Owings Mills, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Shipped 12/19/1959 | 12/19/1959 | Greenwald Mc | Greenwald Mc |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Kate R. Williams | | 24a. REC'D BY REGISTRAR 322 ADDRESS Schuchler & Bates, 44 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Huns | | DATE DEC 22 '59 | |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13362

CERTIFICATE OF DEATH

13362

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

13363

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cockeysville

c. LENGTH OF STAY IN 1b

2 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cockeysville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Wilmar Place

d. STREET ADDRESS

Wilmar Place

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Charles Edward Ford, Sr.

4. DATE OF DEATH

Month

Day

Year

12-29-59

J2

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-9-1880

9. AGE (In years lost birthday) yrs.

79

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

self-employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Ford

14. MOTHER'S MAIDEN NAME

Susan Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

218-03-5028

INFORMANT

Address

Mrs. George H. Wirtz, Sr. Wilmar Pl.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

450.0

Pulmonary Embolism

INTERVAL BETWEEN ONSET AND DEATH

6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

Heart Failure

DUE TO

Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec 1, 1959, to Dec 29, 1959, that I last saw the deceased alive on Dec 27, 1959, and that death occurred at 10:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

George T. Gilmore M.D.

ADDRESS (Street, city or town, state)

Lathemville, MD 12/31/59

DATE SIGNED

PHYSICIAN'S NAME (Type)

GEORGE T. GILMORE

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1-2-59

22c. NAME OF CEMETERY OR CREMATORY

Poplar Grove

22d. LOCATION (City, town, or county)

Cockeysville, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Brooks Funeral Service

ADDRESS

622 York Rd. Towson 4, Md.

24a. REC'D BY REGISTRAR

JAN 4 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

1938

DEPARTMENT OF THE ARMY

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13389
CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3401-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Frank Middle Mitchell Last Ford | | | | 4. DATE OF DEATH
Month December Day 4 Year 19 59 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
18912 Apr. 10 | 9. AGE (In years last birthday)
68 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
accountant | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
215-05-5094 | | 17. INFORMANT
Records; SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac failure
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | | (County) | (State) | |
| 21. I certify that I attended the deceased from Dec. 2 , 19 59 , to Dec. 4 , 19 59 , that I last saw the deceased alive on Dec. 4 , 19 59 , and that death occurred at 2:45a. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Stella Wachslar | | | ADDRESS (Street, city or town, state)
SPRING GROVE STATE HOSPITAL | | DATE SIGNED
12-4-59 | | |
| PHYSICIAN'S NAME (Type)
Stella Wachslar, M. D. | | | Catonsville 28, Md. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/8/1959 | 22c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | 22d. LOCATION (City, town, or county)
Pikesville Maryland | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arthur S. Kraw | | | ADDRESS
Elsworth Armacost-4600 Liberty Hghts. Ave. | | 24a. REC'D BY REGISTRAR
DATE DEC 8 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraw | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13390

CERTIFICATE OF DEATH

Reg. Dist. No.

13365

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
23 Hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle A. Last FORKIN | | 4. DATE OF DEATH
Month DECEMBER Day 27 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/28/78 |
| 9. AGE (In years lost birthday)
81 yrs. | | 10. IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Automobiles | |
| 11. BIRTHPLACE (State or foreign country)
Scranton, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Patrick Forkin | | 14. MOTHER'S MAIDEN NAME
Ann Caffley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
213-03-0218 | |
| 17. INFORMANT
Clin. Rec. VA Hosp. Balto. Md. Ft. Howard Divison | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
420.1 IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) OLD CORONARY OCCLUSION
DUE TO
(c) OLD MYOCARDIAL INFARCTION | | | |
| INTERVAL BETWEEN ONSET AND DEATH
SUDDEN
SEVERAL YRS
SEVERAL yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
GENERALIZED ARTERIOSCLEROSIS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December 26, 19 59 to December 27, 19 59 and that death occurred at 2:00 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) VAH, BALTO. MD. FORT HOWARD DIVISION DATE SIGNED
ACTUAL SIGNATURE Clovis M. Snyder M.D. VAH, BALTO. MD. FORT HOWARD DIVISION
PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER, M.D. VAH, BALTO. MD. FT. HOWARD DIVISION 12/28/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-30-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc. | | 24a. REC'D BY REGISTRAR
ANN 4 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | |

CERTIFICATE OF DEATH

13390

Decedent

Informant

Relationship

Age

Sex

Place of Birth

Place of Death

Date

Time

Color

Sex

Height

Weight

Build

Complexion

Hair

Eyes

Occupation

Education

Marital Status

Religion

Cause of Death

Manner of Death

Signature of Informant

Signature of Decedent

Signature of Physician

Signature of Registrar

Signature of Medical Examiner

Signature of Coroner

Signature of Jury

Signature of Witnesses

Decedent's Name

Decedent's Address

Decedent's Date of Birth

Decedent's Place of Birth

Decedent's Occupation

Decedent's Education

Decedent's Marital Status

Decedent's Religion

1. FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13366

| | | | | | |
|--|------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE North Carolina b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS | | |
| 3. NAME OF DECEASED
(Type or print) | | | 4. DATE OF DEATH | | |
| First Middle Last | | | Month Day Year | | |
| ARTHUR J. FORTNER | | | December 3 1959 | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Jan. 26 1904 | 54 yrs. | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| Seaman | | | Alexander Co. N. C. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Jeff Fortner | | | Roxie Dowell | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | |
| (If yes give year or dates of service) | | | 240 10 8703 | | |
| 17. INFORMANT | | | Address | | |
| | | | Seafarers International Union I216 E. Balto St. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease | | | | | |
| 420.0 DUE TO | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 19 | | | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| DATE SIGNED 12/4/59 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | |
| Removal | | 12/4/59 | | North Carolina | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | 24a. REC'D BY REGISTRAR | |
| Philip Herwig Sons | | 2024 Orleans St | | DEC 8 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE | |
| | | | | Arthur L. Kline | |

13300

13301

North Carolina

Washington

Washington

Washington

Washington

Washington

1

Washington

Washington

Washington

Washington

Washington

13392

CERTIFICATE OF DEATH

Reg. Dist. No. 13367

| | | | |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE CALIFORNIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
COCKEYSVILLE | | c. LENGTH OF STAY IN TB
32 MONTHS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MASONIC HOME | | d. STREET ADDRESS
TURLOCK 43X-3 | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
ELI FOXALL | | 4. DATE OF DEATH
Month Day Year
12 14 1959 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-27-1980 |
| 9. AGE (In years last birthday)
79 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ENGINEERING | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
ENGLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
BENJAMIN FOXALL | | 14. MOTHER'S MAIDEN NAME
PHOEBE BUTLER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Frank L. Smith Jr. - Cockeysville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Cardis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
2 years | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-16 , 19 57 , to 12-14 , 19 59 , that I last saw the deceased alive on 12-14 , 19 59 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Arthur T. Kress | | ADDRESS (Street, city or town, state)
Cockeysville, Md. | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED
12/14/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | 22b. DATE THEREOF
12-16-159 | 22c. NAME OF CEMETERY OR CREMATORY
Wiley Ford Cemetery | 22d. LOCATION (City, town, or county) (State)
Wiley Ford, West Va |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kress | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-10-1933

| | | | | | | | | | |
|--|--|-------------------------------------|--|------------------------------------|--|-------------------------------------|--|------------------------------------|--|
| 1. NAME OF DECEASED
JAMES H. HARRIS | | 2. SEX
Male | | 3. AGE
68 | | 4. DATE OF BIRTH
1-1-1865 | | 5. PLACE OF BIRTH
BALTIMORE, MD | |
| 6. OCCUPATION
Retired | | 7. MARITAL STATUS
Married | | 8. DATE OF MARRIAGE
1-1-1890 | | 9. NAME OF SPOUSE
Mary H. Harris | | 10. DATE OF DEATH
1-10-1933 | |
| 11. PLACE OF DEATH
Home | | 12. CAUSE OF DEATH
Heart Failure | | 13. DISEASE OR INJURY
None | | 14. PERIOD OF ILLNESS
None | | 15. TIME OF DEATH
10:00 AM | |
| 16. SIGNATURE OF DECEASED
None | | 17. SIGNATURE OF WITNESS
None | | 18. SIGNATURE OF PHYSICIAN
None | | 19. SIGNATURE OF CLERK
None | | 20. SIGNATURE OF REGISTRAR
None | |

1. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

2. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

3. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

4. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

5. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

6. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

7. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

8. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

9. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

10. I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.

13393

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Timonium | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Timonium | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
23 Evans Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First SHAUN Middle FRAZIER Last | | 4. DATE OF DEATH
Month December Day 3 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 18, 1959 |
| 9. AGE (In years lost birthday) yrs. 5 Months 15 | | IF UNDER 1 YEAR 15 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Baby | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Paul F. Frazier | |
| 14. MOTHER'S MAIDEN NAME
Marilyn Hawkinson | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
None | | INFORMANT Address
Paul F. Frazier, 23 Evans Ave., Timonium, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE
501X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ASTHMATIC BRONCHITIS DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
3 Hours
2 DAYS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from Dec 2, 1959 , to Dec 3, 1959 , that I last saw the deceased alive on Dec 2, 1959 , and that death occurred at 4 A. M. from the causes and on the date stated above. | |
| ACTUAL SIGNATURE William A Pillsbury M.D. | | ADDRESS (Street, city or town, state) 2060 YORK RD DATE SIGNED 12/4/59 | |
| PHYSICIAN'S NAME (Type) WILLIAM A PILLSBURY | | TIMONIUM, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Dec. 5, 1959 | 22c. NAME OF CEMETERY OR CREMATORY
St. Joseph's Cemetery | 22d. LOCATION (City, town, or county) (State)
Texas, Balto. Co., Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John Burns' Sons, Towson, Maryland | | 24a. REC'D BY REGISTRAR
DATE DEC 7 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur L. Huns |

2048252XU3

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

13393

Bel Shore

Bel Shore

Bel Shore

Timonium

Timonium

22 Irvine Avenue

22 Irvine Avenue

SHAW

SHAW

December 2, 1959

White

White

2 12

Baby

16 Home

Kentland

USA

Paul F. Prosser

Paul F. Prosser

None

None

Paul F. Prosser, 22 Irvine Ave., Timonium, Md.

Dec. 2, 1959

Dec. 2, 1959

Dec. 2, 1959

John H. Hays, Jr., Towson, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13369

13394

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY V | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
COCKEYSVILLE | | c. LENGTH OF STAY IN 1b
21 MONTHS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MASONIC HOME | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First IRENE Middle T Last FREEDBURGER | | 4. DATE OF DEATH
Month DEC Day 10 Year 1959 | |
| 5. SEX
FE | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB 4, 1885 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ARTIST | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S | |
| 13. FATHER'S NAME
CARROLL S. FREEBURGER | | 14. MOTHER'S MAIDEN NAME
MARY DERRINGER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Frank L. Smith Jr. - Cockeysville, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
1 1/2 years | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3-22, 1957 , to 12-9, 1959 , that I last saw the deceased alive on 12-9, 1959 , and that death occurred at 5 P. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Frank L. Smith Jr. | | ADDRESS (Street, city or town, state)
Cockeysville, Md | |
| DATE SIGNED
12/10/59 | | M.D. | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
12-12-59 | 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 22d. LOCATION (City, town, or county) (State)
Baltimore |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR
DATE DEC 14 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. House | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13395

CERTIFICATE OF DEATH

13370

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission]
o. STATE <u>MD</u> b. COUNTY <u>City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural: Towson</u> | | | c. LENGTH OF STAY IN 1b
<u>4 Mos.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore City</u> 3 Vol-4 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Eudowood Sanatorium</u>
<u>Towson 4, Maryland</u> | | | | d. STREET ADDRESS
<u>925 E BALTIMORE ST</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Friedland</u> Last <u></u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>23</u> Year <u>1959</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9/29/1907</u> | |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS.
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | |
| 13. FATHER'S NAME
<u>Abraham Lewis</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dolcie Weinberg</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u></u> | | 17. INFORMANT
Address <u>Personal History</u>
<u>Hospital Records, Eudowood Sanatorium</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u>
DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>15 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>10/8</u> , 19 <u>59</u> , to <u>12/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>59</u> , and that death occurred at <u>6:40 P</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Eudowood Sanatorium</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u> | | | | DATE/SIGNED <u>12/23/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-24-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Herring Run</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jack Lewis Inc</u> | | | | ADDRESS
<u>2100 Eutaw Pl</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 28 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | | | | | | |

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

| | | | | | | | | | |
|-----------------------|--|----------------------|--|-----------------------------|--|-----------------------------|--|---------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | M | | 45 | | JAN 15 1892 | | BALTIMORE, MD. | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| 1234 E. BALTIMORE ST. | | LABORER | | HEART DISEASE | | NATURAL | | HOSPITAL | |
| DATE OF DEATH | | TIME OF DEATH | | HOURS OF DEATH | | MINUTES OF DEATH | | SECONDS OF DEATH | |
| JAN 20 1937 | | 10:30 AM | | 10 | | 30 | | 00 | |
| PLACE OF DEATH | | DATE OF DEATH | | TIME OF DEATH | | HOURS OF DEATH | | MINUTES OF DEATH | |
| HOSPITAL | | JAN 20 1937 | | 10:30 AM | | 10 | | 30 | |
| NAME OF PHYSICIAN | | NAME OF NURSE | | NAME OF ATTENDING PHYSICIAN | | NAME OF ASSISTANT PHYSICIAN | | NAME OF PATHOLOGIST | |
| DR. J. H. HARRIS | | MISS J. H. HARRIS | | DR. J. H. HARRIS | | DR. J. H. HARRIS | | DR. J. H. HARRIS | |
| NAME OF FUNERAL HOME | | NAME OF BURIAL PLACE | | NAME OF CEMETERY | | NAME OF INTERMENT | | NAME OF INTERMENT | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |
| NAME OF FUNERAL HOME | | NAME OF BURIAL PLACE | | NAME OF CEMETERY | | NAME OF INTERMENT | | NAME OF INTERMENT | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13371

13395

| | | | | | | | |
|--|---|--|--|--|--|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bendix Radio Corp. Joppa Rd | | | | d. STREET ADDRESS
623 Denison St | | | |
| 3. NAME OF DECEASED (Type or print)
First Richard Middle A Last Galiszewski | | | | 4. DATE OF DEATH Dec. 11/59 Month 11 Day 19 Year 19 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 6, 1914 | 9. AGE (In years last birthday)
45 yrs. | IF UNDER 1 YEAR
Months 11 Days 11 | IF UNDER 24 HRS.
Hours 11 Min. 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Buyer | | 10b. KIND OF BUSINESS OR INDUSTRY
Bendix Radio Corp. | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Felix Galiszewski | | | | 14. MOTHER'S MAIDEN NAME
Katherine Harnek | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
218 14 9293 | | 17. INFORMANT Address St
Mrs. Catherine Galiszewski, 623 Denison | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (b) Sudden
(c) Sudden
DUE TO Sudden
DUE TO Sudden
DUE TO Sudden | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour 19 a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/11/59 | | | |
| EXAMINER'S NAME (Type)
Charles F. O'Donnell | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/14/59 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 22d. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Witzke Funeral Directors
4101 E. Amundson Ave. | | | | 24a. REC'D BY REGISTRAR
DATE DEC 15 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1883

| | | | |
|-----------------------|--|-----------------------|--|
| NAME OF DECEASED | | FELIX GELISZOWSKI | |
| AGE | | 35 | |
| SEX | | MALE | |
| RACE | | POLISH | |
| DATE OF DEATH | | JAN. 11/23 | |
| PLACE OF DEATH | | BALTIMORE, MD. | |
| CAUSE OF DEATH | | TUBERCULOSIS OF LUNGS | |
| MANNER OF DEATH | | NATURAL | |
| SIGNATURE OF EXAMINER | | J. H. HARRIS | |
| DATE OF SIGNATURE | | JAN. 11/23 | |
| PLACE OF SIGNATURE | | BALTIMORE, MD. | |
| NAME OF DECEASED | | FELIX GELISZOWSKI | |
| AGE | | 35 | |
| SEX | | MALE | |
| RACE | | POLISH | |
| DATE OF DEATH | | JAN. 11/23 | |
| PLACE OF DEATH | | BALTIMORE, MD. | |
| CAUSE OF DEATH | | TUBERCULOSIS OF LUNGS | |
| MANNER OF DEATH | | NATURAL | |
| SIGNATURE OF EXAMINER | | J. H. HARRIS | |
| DATE OF SIGNATURE | | JAN. 11/23 | |
| PLACE OF SIGNATURE | | BALTIMORE, MD. | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13372

13397

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON | | c. LENGTH OF STAY IN 1b
55 TOWSON | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
TOWSON CONVELSCENT HOME | | d. STREET ADDRESS
406 CENTRAL AVENUE | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
HARMON PAUL GESSFORD | | 4. DATE OF DEATH
Month Day Year
DECEMBER 23 1959 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8 APRIL 1902 |
| 9. AGE (In years last birthday)
57 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
OFFICE MANAGER | | 10b. KIND OF BUSINESS OR INDUSTRY
SOUTHERN FUEL CORP. MARYLAND | |
| 11. BIRTHPLACE (State or foreign country)
USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
PAUL GESSFORD | | 14. MOTHER'S MAIDEN NAME
ALICE PRYOR | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO NONE | | 16. SOCIAL SECURITY NO.
219-14-3607 | |
| INFORMANT Address
MRS. ELIZABETH W. GESSFORD 406 CENTRAL AVE. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of liver
581.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
2 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Nov , 19 57 , to Dec 23 , 19 59 , that I last saw the deceased alive on Dec 22 , 19 59 , and that death occurred at 2:30 AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Robert T. Barker M.D. M.D. | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
26 DEC 59 | 22c. NAME OF CEMETERY OR CREMATORY
PROSPECT HILL CEMETERY | 22d. LOCATION (City, town, or county) (State)
TOWSON MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John Burns Son's Towson Md. | | 24a. REC'D BY REGISTRAR
DEC 28 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur L. House |

1

VS A1S (4)
ISM 9/58

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1889

BALTIMORE

MARYLAND

TOWN

WYOMING

ADD THE LAST TWO

THE 100/1000000000

DECEASED

DATE

NAME

9 APRIL 1903

WILLIAM

MALE

SOUTHERN RAIL CO. BALTIMORE

CHIEF MANAGER

ALICE PRYOR

PAID DEPOSIT

250-1-3007 THE WILLIAM W. GREENWOOD 100 CENTRAL AVE.

HOME

NO

13330

CERTIFICATE OF DEATH

Reg. Dist. No.

13373

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTO. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK | | | | c. LENGTH OF STAY IN 1b 7 YRS. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1904 JACKSON RD. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES WILLIAM GETZ | | | | 4. DATE OF DEATH DEC. 20 1959 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB. 11, 1896 | |
| 9. AGE (In years last birthday) 63 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC | | 11. BIRTHPLACE (State or foreign country) PENNA. RAILROAD MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME HERMAN GETZ | | | | 14. MOTHER'S MAIDEN NAME LOUISA WIEGAND | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 717-07-7196 | | | |
| 17. INFORMANT MRS. MARG. MAY GETZ | | | | Address 1904 JACKSON RD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 193.0 Brain cancer, primary
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of rectum,
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 1 year
1 year | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from Nov. 19 58 to 20 Dec. 19 59 , that I last saw the deceased alive on 19 Dec. 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Morris Rainess | | | | ADDRESS (Street, city or town, state) 1105 OLD EASTERN AVE. | | | |
| PHYSICIAN'S NAME (Type) MORRIS RAINESS, MD. | | | | DATE SIGNED 12-21-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF DEC. 23, 1959 | | 22c. NAME OF CEMETERY OAK LAWN | |
| 22d. LOCATION (City, town, or county) BALTO. CO. | | | | (State) MD. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann | | | | ADDRESS 3218 HUDSON ST. | | 24a. REC'D BY REGISTRAR DEC 22 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | | | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1875

CERTIFICATE OF DEATH

1875

BALTO

MD

BALTO

CHURCH 7 YRS. DUNDALK

JOHN JACKSON JR. 1904 JACKSON RD

CHARLES WILLIAM GETZ DEC. 20 1875

MARY WHITE FEB. 11 1844

MECHANIC 1844 BALTO MD USA

HERMAN GETZ LOUISA WIEGAND

NO. 1111 THE MRS. MARY GETZ 1104 JACKSON

CLARK DENNIS 1844 BALTO. CO MD

BALTO. CO 248 JACKSON ST.

CERTIFICATE OF DEATH

Reg. Dist. No.

13374

13398

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Parkville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Parkville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>7901 Oakleigh Rd.</i> | | d. STREET ADDRESS
<i>7901 Oakleigh Rd.</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Hilda</i> Middle <i>Amelia</i> Last <i>Giannaccini</i> | | 4. DATE OF DEATH
Month <i>Dec.</i> Day <i>29</i> Year <i>1959</i> | |
| 5. SEX
<i>female</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<i>April 5, 1903</i> |
| 9. AGE (In years last birthday) yrs. <i>56</i> | | IF UNDER 1 YEAR
Months <i>56</i> Days <i>36</i> Hours <i>36</i> Min. | IF UNDER 24 HRS.
Months <i>56</i> Days <i>36</i> Hours <i>36</i> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>Walter W. Lutz</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Amelia Captain</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | INFORMANT
<i>John W. Kruse</i> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>420.1 Coronary Thrombosis</i>
DUE TO (b) <i>Arterio Sclerotic Myocardioses</i>
DUE TO (c) <i>2 yrs</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>8 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 18. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>9/6</i> , 19 <i>59</i> , to <i>12/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/24</i> , 19 <i>59</i> , and that death occurred at <i>139</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>Wm Conway</i> | | DATE SIGNED
<i>8358 Loch Raven Blvd. Towson 4, Md.</i> | |
| PHYSICIAN'S NAME (Type)
<i>W. m. Conway M.D.</i> | | M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | 22b. DATE THEREOF
<i>1-2-1960</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Leonard J. Ruck</i> | | ADDRESS
<i>5305 Harford Rd</i> | |
| 24a. REC'D BY REGISTRAR
<i>DEC 31 59</i> | | 24b. REGISTRAR'S SIGNATURE
<i>John D. H. H. H.</i> | |

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13399

CERTIFICATE OF DEATH

13375

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
302 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle E. Last GIBSON | | 4. DATE OF DEATH
Month December Day 30 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 1, 1919 |
| 9. AGE (In years last birthday)
40 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tractor Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles E. Gibson | | 14. MOTHER'S MAIDEN NAME
Martha Washington | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
220-07-3334 | |
| 17. INFORMANT
Clin. Records VAH Balto 18 Md Ft Howard Division | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA DUE TO CHRONIC GLOMERULONEPHRITIS
592x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 2, 1959 to December 30, 1959 , and that death occurred at 11:12 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
VAH, BALTO. MD. FT HOWARD DIV 12/31/59 | | | |
| ACTUAL SIGNATURE Martin W. Gottlieb M.D. | | DATE SIGNED 12/31/59 | |
| PHYSICIAN'S NAME (Type) MARTIN W. GOTTLIEB, M. D. | | DATE SIGNED 12/31/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/4/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Balto. National Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Herbert Nutter Funeral Home, 3810 Bonner Rd. Balto. Md. | | 24a. REC'D BY REGISTRAR
JAN 4 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

18389

CERTIFICATE OF DEATH

1937

First Name: [illegible]
Last Name: [illegible]
Sex: [illegible]
Age: [illegible]
Date of Birth: [illegible]
Place of Birth: [illegible]
Cause of Death: [illegible]
Date of Death: [illegible]
Place of Death: [illegible]
Signature: [illegible]
Registrar: [illegible]

Yes [illegible] No [illegible]
[illegible] [illegible] [illegible] [illegible]

Register No. [illegible]
Date of Registration [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]

13400
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Upperco | | c. LENGTH OF STAY IN 1b
13yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Trenton Road | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Rachel Virginia (Jennie) Gill | | 4. DATE OF DEATH
Dec. 17, 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 28, 1881 |
| 9. AGE (In years last birthday)
78 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
John Wesley Price | | 14. MOTHER'S MAIDEN NAME
Amanda Derr | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Mitchell Hale, Upperco, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
2 days
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1950 , to Dec 17, 1959 , that I last saw the deceased alive on Dec 16, 1959 , and that death occurred at 10:30 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. H. Foard | | ADDRESS (Street, city or town, state) DATE SIGNED MANCHESTER, MD 12-17-59 | |
| PHYSICIAN'S NAME (Type) W. H. Foard M.D. | | MANCHESTER, MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Dec. 19, 1959 | 22c. NAME OF CEMETERY OR CREMATORY
St. Paul | 22d. LOCATION (City, town, or county) (State)
Arcadia, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. F. Eline & Sons, Reisterstown, Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanks | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13377

13401

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
5mth3dys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
La Platta, Maryland | | 08x-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS
Star Route #3 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Milford Middle Hancock Last Hancock | | 4. DATE OF DEATH
Month December Day 10 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
Sept. 9, 1877 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Unknown (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lymphosarcoma of pharynx
200.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 28, 19 59 to December 10, 19 59 , that I last saw the deceased alive on Dec. 10, 19 59 , and that death occurred at 10:10a. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachsler | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 10-15-59 | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville, 28, Maryland | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/7/59 | 22c. NAME OF CEMETERY OR CREMATORY
Catonsville | 22d. LOCATION (City, town, or county) (State)
4300 Old Frederick |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. J. Zaher | | 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | |
| ADDRESS
1318 Light | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hana | |

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13402

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Howard | | | | c. LENGTH OF STAY IN 1b 6 hours 15 min. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 1903 W Baltimore St | | | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle J Last HECKER | | | | 4. DATE OF DEATH
Month December Day 6 Year 19 59 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 10, 1893 | | 9. AGE (In years last birthday) 66 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Bakery Shop | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Edward Hecker | | | |
| 14. MOTHER'S MAIDEN NAME Marie Harberman | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I | | | |
| 16. SOCIAL SECURITY NO. 218-28-7628 | | | | 17. INFORMANT Address Clin Rec VAH Balto 18, Md Ft Howard Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS LEFT MIDDLE CEREBRAL ARTERY
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) EDEMA LUNGS DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH 3 days
12 hours | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis ; Diabetes Mellitus | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) VA | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 10:15AM Dec 6 19 59 to 4:30PM Dec 6 19 59 and that death occurred at 4:30PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John W. Crawford | | | | ADDRESS (Street, city or town, state) VAH BALTO 18, MD FT HOWARD DIV. | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD M.D. | | | | DATE SIGNED 12/7/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 12-10-59 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | | | 22e. (State) | | 22f. (County) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc | | | | ADDRESS 6009 Harford Rd Balto 14, Md | | 24a. REC'D BY REGISTRAR DEC 9 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | DATE DEC 9 '59 | | | |

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934

CERTIFICATE OF DEATH

1934



Blank form with faint lines and text for a Certificate of Death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13379

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore 13403
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Middle River | | c. LENGTH OF STAY IN 1b
54 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
440 White Thorn Way | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) PEARL MAE HEDDERMAN | | 4. DATE OF DEATH
Month December Day 28 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 21, 1893 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Peter Kraft | |
| 14. MOTHER'S MAIDEN NAME
Sara Lynch | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO.
---- | | 17. INFORMANT
Mr. Edward Brown-440 White Thorn Way -20 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease
DUE TO (b) Disease
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH

 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | 20c. TIME OF INJURY
Month, Day, Year
Hour 19 o. m. p. m. | |
| 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| 20f. (City or town)
Baltimore | | 20g. (County)
Baltimore | |
| 20h. (State)
Maryland | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | |
| ACTUAL SIGNATURE
M. B. Davis M.D. | | DATE SIGNED
12/29/59 | |
| EXAMINER'S NAME (Type)
M. B. DAVIS M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 31, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 22d. LOCATION (City, town, or county)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Sander & Sons, Inc. Balto., Md. | | 24a. REC'D BY REGISTRAR
JAN 4 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--------------------------------------|--|---------------------------------------|--|--------------------------------------|--|--------------------------------------|--|---|--|--------------------------------------|--|
| NAME OF DECEASED
JAMES H. HARRIS | | AGE
45 | | SEX
Male | | RACE
White | | DATE OF DEATH
10/15/1910 | | PLACE OF DEATH
New York City | |
| RESIDENCE
1234 Broadway | | OCCUPATION
Clerk | | EDUCATION
High School | | MARRIAGE
Married | | SINGLE | | WIDOWED | |
| CAUSE OF DEATH
Heart Disease | | MANNER OF DEATH
Natural | | DISEASES PREEXISTING
Hypertension | | DISEASES ACQUIRED
None | | DISEASES PRESENT
Myocardial Infarction | | DISEASES PREVIOUS
None | |
| SIGNATURE OF EXAMINER
J. H. Smith | | SIGNATURE OF DECEASED
J. H. Harris | | SIGNATURE OF WITNESS
J. H. Harris | | SIGNATURE OF WITNESS
J. H. Harris | | SIGNATURE OF WITNESS
J. H. Harris | | SIGNATURE OF WITNESS
J. H. Harris | |
| LOCALITY
New York City | | COUNTY
New York | | STATE
New York | | CITY
New York | | TOWN
New York | | VILLAGE
New York | |

13404

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Balto. Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Catonsville</i> | | c. LENGTH OF STAY IN 1b
<i>52</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>House in Linda Home</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>LAURA C. HEINMUELLER</i> | | 4. DATE OF DEATH
Month <i>Dec.</i> Day <i>4</i> Year <i>1959</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>2/21/77</i> |
| 9. AGE (In years last birthday)
<i>82</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>82</i> Days <i>82</i> Hours <i>82</i> Min. | 11. IF UNDER 24 HRS.
Months <i>82</i> Days <i>82</i> Hours <i>82</i> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Homemaker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Edw. Seidel</i> | | 14. MOTHER'S MAIDEN NAME
<i>Margaret Mosberger</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>Miss Hilda Heinmuller</i> | |
| 17. INFORMANT
<i>Miss Hilda Heinmuller</i> | | Address <i>12-6</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arterio Sclerotic C.V. Disease</i>
422.1 DUE TO <i>Angioma of Left @ Torus</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>1 wk</i>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture of Left Hip-</i> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | |
| 20c. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <i>10-1</i> , 19 <i>56</i> , to <i>12-4</i> , 19 <i>59</i> that I last saw the deceased alive on <i>12-4-59</i> , 19 <i>59</i> , and that death occurred at <i>1 P.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>James E. Howard</i> M.D. | | ADDRESS (Street, city or town, state) <i>Catonsville</i> DATE SIGNED <i>12-6</i> | |
| PHYSICIAN'S NAME (Type) <i>James E. Howard</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/7/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i> | | 22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Webb + Son</i> ADDRESS <i>28</i> | | 24a. REC'D BY REGISTRAR <i>DEC 8 '59</i> DATE | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

State of New York, County of ...

On this ... day of ... 1900

I, the undersigned, a duly qualified ...

do hereby certify that ...

... died on the ... day of ... 1900

at the age of ... years

... of the County of ...

State of New York

Signature of ...

...

...

...

...

...

...

...

...

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...

...

...

...

...

CERTIFICATE OF DEATH

Reg. Dist. No.

13381

13405

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>17Aigburth Road Towson #4</u>
<u>Baltimore County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson #4</u> | | c. LENGTH OF STAY IN lb
<u>33 Years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
<u>17Aigburth Road</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Margaret Johnston Herring</u> | | 4. DATE OF DEATH
Month Day Year
<u>Dec 18 1959</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct 27-1888</u> |
| 9. AGE (In years lost birthday)
<u>71</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>✓</u> | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Md</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>William Lee Johnston</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Marriott Blake</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Robert Q. Herring (Husband)</u> | |
| 17. INFORMANT
<u>Robert Q. Herring (Husband)</u> | | Address
<u>Towson #4 17Aigburth Road</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u>
<u>491X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>BRONCHO-PNEUMONIA, BILATERAL</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 HOURS</u>
<u>1 DAY</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/18</u> , 19 <u>59</u> , to <u>12/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>17 W. Pennsylvania Avenue, Towson 4, Md.</u>
DATE SIGNED <u>12/18/59</u> | | | |
| ACTUAL SIGNATURE <u>T. C. Siwinski</u> | | M.D. <u>17 W. Pennsylvania Avenue, Towson 4, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
<u>DEC 21, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>DULANEY VALLEY MEM'L GARDENS</u> | 22d. LOCATION (City, town, or county) (State)
<u>BALTIMORE MARYLAND</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>HENRY W. JENKINS SONS</u> | | ADDRESS
<u>4905 YORK ROAD</u> | |
| 24a. REC'D BY REGISTRAR
<u>DEC 21 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kline</u> | |

CERTIFICATE OF DEATH

1925

State of Maryland, County of Baltimore, City of Baltimore, I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 12th day of December, 1925, at the residence of the deceased, the following named person died:

Name of deceased: William L. McMillan

Age: 33 years

Sex: Male

Color: White

Height: 5 feet 10 inches

Weight: 160 pounds

Occupation: Engineer

Usual Residence: 1111 North Avenue, Baltimore, Md.

Place of Death: At home

Cause of Death: Myocardial Infarction

Immediate Cause: Coronary Thrombosis

Underlying Cause: Arteriosclerosis

Contributing Cause: None

Signature of Physician: W. L. McMillan

Signature of Registrar: W. L. McMillan

Signature of Coroner: W. L. McMillan

Signature of Minister: W. L. McMillan

Signature of Undertaker: W. L. McMillan

Signature of Burial: W. L. McMillan

Signature of Interment: W. L. McMillan

Signature of Burial: W. L. McMillan

13406

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
14 Forge Haven Drive | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First THELMA Middle ISSABELLE Last HERTZOG | | 4. DATE OF DEATH
Month December Day 29 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 27, 1910 |
| 9. AGE (In years lost birthday)
49 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At home | |
| 11. BIRTHPLACE (State or foreign country)
Penna | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William D. McKean | | 14. MOTHER'S MAIDEN NAME
Iva Beachel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No. | | 16. SOCIAL SECURITY NO.
Robert L. Hertzog | |
| 17. ADDRESS
14 Forge Haven Drive | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dermato mycosis
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 29, 1959 to Dec 29, 1959 , that I last saw the deceased alive on 19 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leopoldo Gross | | ADDRESS (Street, city or town, state) 201 Ballard Ave Baltimore Md | |
| PHYSICIAN'S NAME (Type) Leopoldo Gross MD | | DATE SIGNED Dec 31 '59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/31/59 | 22c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home 4210 Belair Road. | | 24a. REC'D BY REGISTRAR
DATE DEC 31 '59 | |
| 24b. REGISTRAR'S SIGNATURE
C. H. H. H. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12406
CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Birth | |
| John Doe | | 1900-01-01 | |
| Sex | | Age | |
| Male | | 45 | |
| Race | | Marital Status | |
| White | | Married | |
| Occupation | | Cause of Death | |
| Farmer | | Heart Disease | |
| Place of Death | | Date of Death | |
| Home | | 1950-03-15 | |
| Signature of Physician | | Signature of Registrar | |
| [Signature] | | [Signature] | |
| Name of Physician | | Name of Registrar | |
| Dr. J. P. Smith | | John Doe | |
| Address of Physician | | Address of Registrar | |
| 123 Main St. | | 456 Main St. | |
| City | | City | |
| State | | State | |
| County | | County | |
| Zip | | Zip | |

1 ~~X~~

13383

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13407

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
6405 Pinehurst Rd. | | d. STREET ADDRESS
6405 Pinehurst Rd. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle R. Last HIMES | | 4. DATE OF DEATH
Month Dec. Day 10 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 5, 1887 |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Rtd (Office Manager) | | 10b. KIND OF BUSINESS OR INDUSTRY
Contractors | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John Himes | | 14. MOTHER'S MAIDEN NAME
Emma Gardner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
Informant Address
Mrs. Helen F. Himes - 6405 Pinehurst Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 451X Ruptured abdominal aneurysm
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
2 hours | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov 10 , 19 59 , to 12/10 , 19 59 , that I last saw the deceased alive on Nov 10 , 19 59 , and that death occurred at M , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 2929 N. Charles Balto Md DATE SIGNED
ACTUAL SIGNATURE Franklin E Leslie M.D. Franklin E Leslie
PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/12/59 | 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm J. Dickner & Sons - Balto, Md | | 24a. REC'D BY REGISTRAR
DATE DEC 10 1959 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13407



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13408

CERTIFICATE OF DEATH

15384

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
c. LENGTH OF STAY IN 1b
52 Catonsville
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
101 N. Rolling Rd. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
101 N. Rolling Rd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
ANNA E. HOLLAND | | 4. DATE OF DEATH
Month Dec. Day 21, Year 1959 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 7, 1885 |
| 9. AGE (In years lost birthday)
74 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | 11. BIRTHPLACE (State or foreign country)
Md. |
| 12. CITIZEN OF WHAT COUNTRY?
Housewife | | 13. FATHER'S NAME
Jacob Wolf | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address
Mr. Gordon M. Holland - 103 N. Rolling Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRA VASCULAR ACCIDENT
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (c) 20YR | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 1, 1957 to Dec 20, 1959 , that I last saw the deceased alive on Dec 20, 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
James E. Rowe M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED
1011 Frederick Road Cat 28, Md. | |
| PHYSICIAN'S NAME (Type)
James E. Rowe, M.D. | | Ri. 7 4252 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/24/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cem. | | 22d. LOCATION (City, town, or county) (State)
Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Pickner & Sons - Balt 17 Md | | 24a. REC'D BY REGISTRAR
DATE DEC 24 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

13409

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McComas Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Chloe Belle Hoshall</u> | | 4. DATE OF DEATH <u>December 21, 1959</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 7, 1872</u> |
| 9. AGE (In years <u>87</u> yrs.) | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>14</u> Hours <u>15</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Hezekiah Best Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Cooper</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Upton Hoshall, White Hall, Md. R.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio Vascular</u>
<u>422.1</u> DUE TO <u>Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> to <u>Dec 21, 1959</u> that I last saw the deceased alive on <u>Dec 21, 1959</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. | | ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>12/21/59</u> | |
| PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/24/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>White Hall, Md. R.D.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hartenstein, New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 24 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove suburban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13402

1

1

CERTIFICATE OF DEATH

Reg. Dist. No.

13386

13410

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY a. b. ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
201 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gambrills 02X-2 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle T. Last HOWARD | | 4. DATE OF DEATH
Month December Day 1 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 14, 1892 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. | 11. IF UNDER 24 HRS.
Months 66 Days 66 Hours 66 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
William Howard | | 14. MOTHER'S MAIDEN NAME
Rachel Robinson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)
Yes (If yes, give war or dates of service)
WW I | | 16. SOCIAL SECURITY NO.
217-07-7039 | |
| 17. INFORMANT
Clin. Records. VAH, Balto. Md. Ft. Howard Division | | Address
Clin. Records. VAH, Balto. Md. Ft. Howard Division | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE BLADDER
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO
(c)
1810
INTERVAL BETWEEN ONSET AND DEATH
5 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that VA attended the deceased from May 14 , 19 59 , to December 1 , 19 59 , and that death occurred at 3:20 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Daniel A. Nieves | | ADDRESS (Street, city or town, state) VAH, BALTIMORE, MD. - FT HOWARD DIV. 12/1/59 | |
| PHYSICIAN'S NAME (Type) DANIEL A. NIEVES, M. D. | | VAH, BALTIMORE, MD. - FT HOWARD DIV. 12/1/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/4/59 | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Glen B. Kirkley | | 24. REC'D BY REGISTRAR
DEC 7 '59 | |
| ADDRESS Hopping & Kirkley Funeral Home, 421 Crain Hwy, Balto. Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kline | |

CERTIFICATE OF DEATH

1911

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

11. Name of registrar: _____

12. Name of hospital: _____

13. Name of doctor: _____

14. Name of nurse: _____

15. Name of attendant: _____

16. Name of undertaker: _____

17. Name of funeral home: _____

18. Name of cemetery: _____

19. Name of church: _____

20. Name of family: _____

21. Name of friends: _____

22. Name of neighbors: _____

23. Name of relatives: _____

24. Name of friends: _____

25. Name of neighbors: _____

26. Name of relatives: _____

27. Name of friends: _____

28. Name of neighbors: _____

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197. Name of relatives: _____

198. Name of friends: _____

199. Name of neighbors: _____

200. Name of relatives: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 13387 | | | |
|--|--|----------------------------|---|--|---|----------------------------------|--|---|----------|---|---------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Rd.</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>Balto.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Arthur</u> Middle <u>Howard</u> Last | | | | | 4. DATE OF DEATH <u>12/25/59</u> Month <u>12</u> Day <u>25</u> Year <u>19</u> | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Wh</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-3-1895</u> | | 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Plumber</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William H. Howard</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>INDIA HOLLAND</u> | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. <u>217-09-5708</u> | | 17. INFORMANT <u>SADDIE HOWARD</u> Address <u>SAME</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(c) <u> </u> DUE TO
(a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>W. Bradley King Jr.</u> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) <u>W. Bradley King Jr. MD</u> | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | 12/25/59 | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 22b. DATE THEREOF <u>12/29/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ST John's Cem.</u> | | | 22d. LOCATION (City, town, or county) <u>LONG GREEN MD.</u> (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>LEONARD J RUCK</u> ADDRESS <u>5305 HARFORD Rd.</u> | | | | | 24a. REC'D BY REGISTRAR <u>DEC 29 59</u> DATE | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13388

13412

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE COUNTY
CATONSVILLE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5926 Cecil Ave. | | d. STREET ADDRESS 15926 Cecil Ave. | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle I Last Isensee | | 4. DATE OF DEATH Month Dec. Day 13 Year 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/23/1872 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME MARTIN TUNNEMANN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT 5926 Cecil Ave. BALTO, MD. Mr. William F. Isensee | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis
422.2 DUE TO Cardiac Distention
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 10 , 19 59 , to Dec 7 , 19 59 , that I lost the deceased alive on Dec 7 , 19 59 , and that death occurred at 4 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James W. Katzenberger | | ADDRESS (Street, city or town, state) 4175 Independence Ave | |
| PHYSICIAN'S NAME (Type) JAMES W. KATZENBERGER | | DATE SIGNED 12/14/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/16/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. Truman Schwab | | ADDRESS 3512 Frederick Ave. 29. | |
| 24a. REC'D BY REGISTRAR DEC 18 1959 | | 24b. REGISTRAR'S SIGNATURE Charles E. Hines | |

13413

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|---|--|---------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u> ✓ | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Owings Mills, Md</u> | | | c. LENGTH OF STAY IN lb
<u>13 days</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Darlington</u> <u>12 x -2</u> | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Rosewood St. Tr. School</u> | | | d. STREET ADDRESS
<u>Box 72 Darlington, Md</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Leon Darnell Jaynes</u> | | | | | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>7-22-59</u> | | 9. AGE (In years last birthday)
<u>yr.</u> | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>4 22</u> | | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u></u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u></u> | | | 11. BIRTHPLACE (State or foreign country)
<u>M.D.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | |
| 13. FATHER'S NAME
<u>Leon Jaynes</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Beulah May Gitting</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
<u></u> | | | 16. SOCIAL SECURITY NO.
<u></u> | | | INFORMANT
<u>Rosewood Records Owings Mills Md</u> | | | Address
<u></u> | | | | |

INTERVAL BETWEEN
ONSET AND DEATH
1 day

Birth

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

(Stote)

DATE SIGNED _____

12/14/59

Rosewood Tr. School, Owings Mills, Md.

| | | | | |
|--|-------------------|------------------------------------|---------------------------------------|---------|
| 22a. BURIAL, CREMATION,
REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) | (State) |
| | Dec 14 1959 | Clark's Chapel Am | Harford Co. | Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE | |
| H. S. Bailey | Harlingford Md | DATE DEC 17 '59 | Arthur L. Thomas | |

~~9VVVVVVVXV~~ 207/392 XV 4

Harford

המחיר הנמוך ביותר של 10 שקלים נקבע על ידי המנהל הכלכלי של המועצה, וזאת כדי להבטיח את תחרותיות המכרז.

3151

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13391

13415

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Cockeysville</i> | | c. LENGTH OF STAY IN 1b
<i>70 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Wright Avenue</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Wilmington Norton M Clesky</i> | | 4. DATE OF DEATH <i>December 19 1959</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>29 August 1889</i> |
| 9. AGE (In years lost birthday)
<i>70</i> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired Nurse</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Cockeysville, Md</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>USA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Nicholas Borley Merryman</i> | | 14. MOTHER'S MAIDEN NAME
<i>Wilmington Norton M Clesky</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>215-01-48923</i> | |
| 17. INFORMANT
<i>Husband</i> | | Address
<i>Same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>
<i>443X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Arteriosclerotic Cardiac</i>
DUE TO <i>vascular disease</i>
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<i>7 yrs</i>
<i>15 yr.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>December 18 1959</i> , to <i>December 19 1959</i> , that I last saw the deceased alive on <i>Dec 18 1959</i> , and that death occurred at <i>7 P</i> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i> DATE SIGNED <i>19 Dec 1959</i> | | | |
| ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D. | | | |
| PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 22b. DATE THEREOF
<i>12/21/59</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Ashwood Church Cem. Cockeysville Md</i> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>H. W. Meier + Son</i> | | ADDRESS
<i>805 N Calvert St</i> | |
| 24a. REC'D BY REGISTRAR
<i>DEC 21 '59</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kenna</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13416

CERTIFICATE OF DEATH

Reg. Dist. No. 13392

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN lb
8 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First BERT Middle W. Last JOHNSON | | | | 4. DATE OF DEATH
Month December Day 16 Year 19 59 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
December 28, 1888 | |
| 9. AGE (In years lost birthday)
70 yrs. | | 10. IF UNDER 1 YEAR
Months 70 Days 70 Hours 70 Min. 70 | | 11. IF UNDER 24 HRS.
Months 70 Days 70 Hours 70 Min. 70 | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waiter - Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | | |
| 11. BIRTHPLACE (State or foreign country)
Battle Creek, Michigan | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Joseph Johnson | | | | 14. MOTHER'S MAIDEN NAME
Jeanette Walker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
158-09-4632 | | | |
| 17. INFORMANT
Clin. Rec., Vet. Adm. Hospital, Ft. Howard Division | | | | Address Baltimore 18, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CEREBRAL ARTERIOSCLEROSIS
DUE TO
(c) UNKNOWN | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Abscess, post thoracic wall, right | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. VA p. m. 19 | | | |
| 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 8, 19 59 to December 16, 19 59 , and that death occurred at 6:10 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John W. Crawford | | | | ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD., FT. HOWARD DIVISION | | | |
| DATE SIGNED 12/18/59 | | | | DATE SIGNED 12/18/59 | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | | | ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | | 22b. DATE THEREOF
12/18/59 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mount Hope Cemetery | | | | 22d. LOCATION (City, town, or county) (State)
Omaha, Nebraska | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arlington S. Phillips, 1808, 10 Monroe St. Balto. Md. | | | | 24a. REC'D BY REGISTRAR
DEC 21 59 | | | |
| ADDRESS 2416 N. 22nd St., Omaha, Nebraska | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thayer | | | |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13417

CERTIFICATE OF DEATH

Reg. Dist. No.

13393

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort Howard</u> | | | c. LENGTH OF STAY IN 1b
<u>61 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Veterans Administration Hospital</u> | | | | d. STREET ADDRESS
<u>724 Riverside Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>CARROLL</u> Middle <u>M.</u> Last <u>JONES, JR.</u> | | | | 4. DATE OF DEATH
Month <u>December</u> Day <u>3</u> Year <u>19 59</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>August 7, 1920</u> | | 9. AGE (In years lost birthday) yrs.
<u>39</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Serviceman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Refrgeration</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Goldsboro, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Carroll M. Jones, Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Delia Meredith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> (If yes, give war or dates of service) <u>WW II</u> | | | | 16. SOCIAL SECURITY NO.
<u>717-10-6403</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GLIOMA, RIGHT TEMPORAL AND OCCIPITAL REGIONS</u>
<u>193.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>EDEMA OF LUNGS</u> DUE TO
(c) <u>CHRONIC PASSIVE CONGESTION, LUNGS, LIVER & SPLEEN</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 YEAR</u>

<u>FEW HOURS</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>VA</u> <u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>October 3, 1959</u> to <u>December 3, 1959</u> and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John W. Crawford</u> | | | | ADDRESS (Street, city or town, state) <u>VAH, BALTO. 18, MD. FORT HOWARD</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u> | | | | DATE SIGNED <u>12/4/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-7-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Cook-Blight, Inc.</u> | | | | 24a. REC'D BY REGISTRAR
<u>DEC 9 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

Page 4

TO HOSPITAL OR FUNERAL HOME: This certificate must be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

5128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13418

CERTIFICATE OF DEATH

Reg. Dist. No.

13394
32

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MD b. COUNTY BALTO. 3V01-4 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
3429 RAVENWOOD AVE BALTO | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | | | d. STREET ADDRESS
3429 RAVENWOOD AVE | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle EDWARD Last JONES | | | | 4. DATE OF DEATH
Month DEC. Day 21 Year 1959 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 3, 1891 | |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
GEORGE T. JONES | | | | 14. MOTHER'S MAIDEN NAME
MARY WINDSOR | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
218-78-1512A | | | |
| 17. INFORMANT
Address
Hospital Records, Mt. Wilson State Hospital | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 12-18 , 19 59 to 12-21 , 19 59 , that I last saw the deceased alive on 12-21 , 19 59 , and that death occurred at 3 A. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | Mt. Wilson, Maryland | | | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | Superintendent | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
12-24-1959 | | 22c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 22d. LOCATION (City, town, or county) (State)
E. NORTH AVE BALTO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Walter Corbin | | | | ADDRESS
5444 Belair Rd. | | 24a. REC'D BY REGISTRAR
DEC 23 59
DATE | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneap | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

JOHN COLEMAN
BORN 1880
DIED 1918

| | | | |
|-----------------------------|--|-----------------|--|
| Name of deceased | | John Coleman | |
| Age | | 38 years | |
| Sex | | Male | |
| Race | | White | |
| Married | | Yes | |
| Occupation | | Farmer | |
| Cause of death | | Typhoid fever | |
| Date of death | | August 12, 1918 | |
| Place of death | | Home | |
| Signature of physician | | [Signature] | |
| Signature of registrar | | [Signature] | |
| Signature of undertaker | | [Signature] | |
| Signature of witness | | [Signature] | |
| Signature of coroner | | [Signature] | |
| Signature of health officer | | [Signature] | |



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE HEALTH OFFICER OF THE CITY OF BALTIMORE, AND A COPY OF IT IS TO BE FURNISHED TO THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13395

13331

| | | | | | | | |
|---|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
53 Dundalk | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7019 Dunbar Road | | | | d. STREET ADDRESS
7019 Dunbar Road | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First IDA Middle S. Last JONES | | | | 4. DATE OF DEATH
Month December Day 1 Year 19 59 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 2, 1884 | 9. AGE (In years last birthday)
75 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Sandridge | | | | 14. MOTHER'S MAIDEN NAME
? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (List, no. or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Mary J. Bowen 7019 Dunbar Road, --22, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month. Day. Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from July 20 , 19 59 , to December 1 , 19 59 , that I last saw the deceased alive on December 1 , 19 59 , and that death occurred at 3 A. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 2900 Dunran Road, DATE SIGNED 12/1/59 | | | | | | | |
| ACTUAL SIGNATURE
B.W. Sollod | | M.D. B.W. Sollod, M.D. | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Dec. 3, 1959 | 22c. NAME OF CEMETERY OR CREMATORY
Mountain Plain Cemetery | 22d. LOCATION (City, town, or county) (State)
Mechum River, Va. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home 2112 Dundalk Ave. | | | | 24a. REC'D BY REGISTRAR
DATE DEC 2 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13419

CERTIFICATE OF DEATH

Reg. Dist. No. 13396

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>9625 Mason Ave.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lawrence</u> Middle <u>Leroy</u> Last <u>Jones</u> | | | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>29</u> Year <u>1959</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 11, 1899</u> | 9. AGE (In years last birthday)
<u>60</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Freight Conductor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>P.R.R.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Leischer Jones</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Alice A. Caltrider</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | INFORMANT Address
<u>Mrs. Bertha Jones, 9625 Mason Avenue</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
241X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Emphysema</u>
DUE TO
(c) <u>Chronic Asthma</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Emphysema & Chronic Asthma</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 12/29</u> , 19 <u>50</u> , to <u>Dec 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>50</u> , and that death occurred at <u>9</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>1123 St Paul SM</u> DATE SIGNED
ACTUAL SIGNATURE <u>H. D. Franklin</u> M.D.
PHYSICIAN'S NAME (Type) <u>Baltimore 2 Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1/2/1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Moreland Mem Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | | | ADDRESS
<u>5305 Harford Rd</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 31 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kraus</u> | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1941

1941

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and location.]

1 M 050 I 2 VS A15 (4) ISM 9/58 13420 13397 Reg. Dist. No. 1 13420 CERTIFICATE OF DEATH 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 15 HOURS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 4308 Mainfield Avenue 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM G. KEES 4. DATE OF DEATH Month Day Year DECEMBER 19 1959 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH August 29, 1891 9. AGE (In years last birthday) yrs. 68 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME CHRISTIAN J. KEES 14. MOTHER'S MAIDEN NAME BETTY SCHMITT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW I 16. SOCIAL SECURITY NO. INFORMANT Clin. Rec. Vet. Adm. Hosp. Balto. Md. Ft. Howard Div 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE & ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) CHRONIC PYELONEPHRITIS WITH UREMIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction, old; bronchopneumonia, left lower lobe; abscess right scrotum; Generalized Arteriosclerosis. 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from December 18, 1959, to December 19, 1959, and that death occurred at 7:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Joseph J. Cillo, M.D. VAH, Baltimore, Md. Ft. Howard Div. PHYSICIAN'S NAME (Type) Joseph J. Cillo M.D. VAH, Baltimore, Md. Ft. Howard Div. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-22-59 22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc., Baltimore, Maryland 24a. REC'D BY REGISTRAR DATE DEC 22 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kneel

100

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

75004

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13398

13421

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonville</u> | | | | c. LENGTH OF STAY IN 1b
<u>52</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>212 Blakney Rd</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LOUIS KESTLER</u>
First Middle Last | | | | 4. DATE OF DEATH <u>Dec. 30 1959</u>
Month Day Year | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 2, 1883</u> | 9. AGE (In years last birthday)
<u>76</u> yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Letter Carrier Post Office</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Ind.</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Ind.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>George Kestler</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Angela</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>Mamie E. Kestler</u> | | | |
| 17. INFORMANT
<u>Mamie E. Kestler</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u>
DUE TO
(c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 hrs</u>
<u>12 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>7/23</u> , 19 <u>55</u> , to <u>12/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/30</u> , 19 <u>59</u> , and that death occurred at <u>11:33 P.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Eli W. Johnson</u> | | | | ADDRESS (Street, city or town, state) <u>3432 Frederick Ave Baltimore 29 Md</u> | | | |
| DATE SIGNED <u>12/31/59</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Eli</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1/2/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Western</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Balto. Ind.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Mrs. Hall + Son</u> | | | | ADDRESS
<u>28</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 4 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

15202

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 Film 6253 12-28-59 et

13422

CERTIFICATE OF DEATH

Reg. Dist. No.

13399

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Howard</u> <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Howard</u> <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b
<u>52</u> <u>Catonsville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>5 Jones Ave.</u> | | | | d. STREET ADDRESS
<u>5 Jones Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>ALICE</u> Middle <u>KING</u> Last | | | | 4. DATE OF DEATH
Month <u>DEC.</u> Day <u>19,</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 2, 1879</u> | |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS.
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Cooksville Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u></u> | |
| 13. FATHER'S NAME
<u>Dennis Sands</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Annie ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u></u> | | 17. INFORMANT
<u>Volatta Johnson</u> Address <u>5 Jones Ave.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>
<u>443x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Mitral Insufficiency</u> I Yr. II Mo. <u>10</u> <u>days</u>
DUE TO
(c) <u>Hypertensive- Arterio-sclerotic Heart Dis.</u> ? | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>I-22-</u> <u>1958</u> , to <u>Dec. 19th., 1959</u> , that I last saw the deceased alive on <u>12-19th</u> <u>1959</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>57 Winters Lane. Balto.</u> DATE SIGNED <u>28-12-19-59</u> | | | | | | | |
| ACTUAL SIGNATURE <u>C.F. Maloney</u>
PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u> | | | | M.D. <u>57 Winters Lane. Balto.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Dec. 22, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>West Liberty Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>West Liberty Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Mrs. Katie Williams</u>
ADDRESS <u>322 N. Schneider St</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 22 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13400

Item 3 Film G254 1-13-60 et

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Edward First Franklin Middle Klein Last | | 4. DATE OF DEATH December 26th 19 59 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 1881 |
| 9. AGE (In years last birthday) 78 yrs. | | 10. IF UNDER 1 YEAR: Months 78 Days 78 Hours 78 Min. 78 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Klein | | 14. MOTHER'S MAIDEN NAME Caroline Roeder | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Emil G. Forthuber, Address same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Charles F O'Donnell | | DATE SIGNED 12/27/59 | |
| EXAMINER'S NAME (Type) Charles F O'Donnell | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12/29/59 | 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Road. | | 24a. REC'D BY REGISTRAR DEC 31 '59 24b. REGISTRAR'S SIGNATURE Colburn S. Kenna | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13401

13424

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3V01.4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Forrest Haven Nursing Home | | d. STREET ADDRESS
1609 S. Charles Street #30 | |
| 3. NAME OF DECEASED (Type or print)
First John Middle William Last Koch | | 4. DATE OF DEATH
Month December Day 6 Year 1959 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 9, 1883 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months 76 Days 76 Hours 76 Min. | 11. IF UNDER 24 HRS.
Months 76 Days 76 Hours 76 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Sinclair Scott Co. Baltimore, Md. | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John Koch | | 14. MOTHER'S MAIDEN NAME
Christiane Heusler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
216-01-1483 | |
| 17. INFORMANT
Frances C. Koch | | Address
1609 S. Charles St. #30 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DISEASE
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) POST CARDIOVASCULAR CARDIO-VASCULAR DISEASE
DUE TO
(c) DISEASE | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Manth, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Nat white of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/1 , 19 59 to 12/6 , 19 59 , that I last saw the deceased alive on 11/6 , 19 59 , and that death occurred at 5 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
John H. Shaw | | ADDRESS (Street, city or town, state)
5800 Edmondson Ave. Baltimore, Md. | |
| PHYSICIAN'S NAME (Type)
John Shaw, M. D. | | DATE SIGNED
12/9/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/9/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 22d. LOCATION (City, town, or county) (State)
Anne Arundel County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | ADDRESS
4107 Wilkens Ave. | |
| 24a. REC'D BY REGISTRAR
DEC 9 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

1944

CENTRAL BUREAU OF DEATH

1944

Baltimore

MD.

Baltimore

Baltimore

1944

Forest Haven Nursing Home 1609 S. Charles Street

John William Koch December 1944

male white Nov. 9, 1883

Carpenter Cincinnati Score Co. Baltimore, Md. U. S. A.

John Koch Christiana Hospital

216-01-1-13 Frances G. Koch 1609 S. Charles St. 30 no

1

John Shaw, M. D. 2800 Edmonson Avenue

Robert H. Hubbard 107 Wilkins Ave. Great Hill Co. Anne Arundel County, Md.

Howard H. Hubbard 107 Wilkins Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13425

CERTIFICATE OF DEATH

Reg. Dist. No. 13402

| | | | | | | | |
|--|------------------------------|---|--------------------------------------|---|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
COCKEYSVILLE | | | | c. LENGTH OF STAY IN 1b
12 1/2 years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 3V01-4 | | | | d. STREET ADDRESS
1634 EAST 31ST ST. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MASONIC HOME | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
MARY E KRAFT | | | | 4. DATE OF DEATH Month Day Year
DEC 22 1959 | | | |
| 5. SEX
FE | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-16-1873 | 9. AGE (In years last birthday)
86 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S | |
| 13. FATHER'S NAME
LOUIS VOGTMANN | | | | 14. MOTHER'S MAIDEN NAME
MARY HEUSI | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT Address
Frank L. Smith Jr - Cockeysville, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
10 years | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11-15 , 19 57 , to 12-21 , 19 59 , that I last saw the deceased alive on 12-21 , 19 59 , and that death occurred at 3:15 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Walter T. Kees | | | | ADDRESS (Street, city or town, state)
Cockeysville, Md | | | |
| DATE SIGNED
12/22/59 | | | | PHYSICIAN'S NAME (Type)
Walter T. Kees | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
12-24-59 | | 22c. NAME OF CEMETERY OR CREMATORY
1st Evangelical Lutheran Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Wm. Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR
DEC 24 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG253 12-10-59 et

CERTIFICATE OF DEATH

13403

13426

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN 1b <u>55</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>420 Aigburth Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>HENRY</u> First <u>E</u> Middle <u>KRIES</u> Last | | DATE OF DEATH <u>December 4</u> 19 <u>59</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OF HAIR <u>White</u> | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1889</u> |
| 9. AGE (In years lost birthday) <u>70</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heating Contractor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry A. Kries</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Ida M. Kries - 420 Aigburth Rd - 4</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO <u>several years</u>
(c) <u>None</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 28, 1956</u> to <u>Jan 4, 1959</u> that I last saw the deceased alive on <u>Dec. 4, 1959</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Leo Schlenger</u> | | ADDRESS (Street, city or town, state) <u>6001 LOCH RAVEN BLVD BALTIMORE - MD</u> DATE SIGNED <u>12/4/59</u> | |
| PHYSICIAN'S NAME (Type) <u>LEO SCHLENGER, M.D.</u> | | <u>BALTIMORE, MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>12-7-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u> | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE - MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. COOK-TOWSON, INC - TOWSON - MD</u> | | ADDRESS <u>420 Aigburth Rd - 4</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 7 1959</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13432

13432



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13404

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
52 Catonsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
In street in front of 6104 Mt. Ridge Rd. | | | | d. STREET ADDRESS
6104 Mt. Ridge Rd. Balt. 28 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
George A. Langenfelder Jr. | | | | 4. DATE OF DEATH
Dec. 20/59 | | 5. AGE (In years last birthday)
41 yrs. | |
| 5. SEX
M | | 6. COLOR OR RACE
Wh | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 3, 1918 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Owner, Meat Stall, Cross St. Market | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Md. | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 13. FATHER'S NAME
Geo. A. Langenfelder, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Dorothy S. Grady | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
215 01 6848 | | 17. INFORMANT
6104 Mount Ridge Road Mrs. Florence Evelyn Langenfelder | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wounds of chest (2), with massive hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Shot by assailant | | | |
| 20c. TIME OF INJURY
1:55 a.m. | | Month, Day, Year
12/20/59 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | |
| | | | | 20f. (City or town)
Catonsville | | (County) Baltimore (State) Me. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
W. Bradley King, Jr., M.D. | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
W. Bradley King, Jr., M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 23/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Louder Park | | 22d. LOCATION (City, town, or county) (State)
Baltimore 29, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Witzke F.D.4101 Edmondson Ave. | | | | 24a. REC'D BY REGISTRAR
DEC 28 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No. **13405****13428**

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE CO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWLEYS QUARTERS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVELSCENT HOME | | d. STREET ADDRESS 1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle WILLIAM Last LAU | | 4. DATE OF DEATH
Month DECEMBER Day 6 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 30, 1877 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER-RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY MINISTRY | 11. BIRTHPLACE (State or foreign country) ENGLAND |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME KARL W. LAU | | 14. MOTHER'S MAIDEN NAME CHRISTINA vonBOHR | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE (If yes, give war or dates of service) NONE | | 16. SOCIAL SECURITY NO. 218-36-0666 | |
| INFORMANT Address MRS. C.W.LAU 402 ALABAMA ROAD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage
DUE TO (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 10 yrs | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Nov 19 59 to Dec 6 59 that I last saw the deceased alive on December 6, 19 59 and that death occurred at M , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED Charles W. Lau | | | |
| ACTUAL SIGNATURE Charles W. Lau M.D. | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 12/9/59 | 22c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GARDEN | 22d. LOCATION (City, town, or county) (State) TIMONIUM MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md. | | 24a. REC'D BY REGISTRAR DEC 11 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BIRMINGHAM

MARYLAND

HOMER'S QUARTERS

1

25

3

PROBATION

100

WILLIAM

CHURCH

25

APRIL 10, 1907

WHITE

MALE

AGE

100

WILLIAM

MINIST - TESTED

CHRISTIAN WORKER

ALL W. L. A.

400 ALABAMA ROAD

218-00-0000 W. C. W. L. A.

HOME

MARYLAND

CERTIFICATE OF DEATH

100/00

100/00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13429

CERTIFICATE OF DEATH

Reg. Dist. No.

13406

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---------------------------|--|---------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>224 Spring Ave.</u> | | | | d. STREET ADDRESS
<u>224 Spring Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Leach</u> | | | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>25</u> Year <u>19 59</u> | | | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-14-1892</u> | 9. AGE (In years last birthday)
<u>67</u> yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days | IF UNDER 24 HRS.
Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Charles J. Itzel</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>S. Franklin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | INFORMANT
<u>Walter E. Leach</u> Address <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>uremia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic nephrosclerosis</u>
(c) <u>Hypertensive arteriosclerotic Cardiovascular disease</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>unknown</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 25</u> , 19 <u>59</u> , and that death occurred at <u>6.4</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Paul G. Mueller</u> | | | | ADDRESS (Street, city or town, state)
<u>6411 Belair Rd</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Dr. Paul G. Mueller</u> | | | | DATE SIGNED
<u>12/26/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 22b. DATE THEREOF
<u>12/28/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St Joseph's Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Texas, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | | | ADDRESS
<u>5305 Harford Rd</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 29 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | | | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13407

13430

| | | | |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | d. STREET ADDRESS <u>133 Parkins St</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>-</u> Last <u>LEE</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>February 28, 1891</u> |
| 9. AGE (In years lost birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Lee</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Smathers</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Clin. Rec. Vet. Adm. Hospital Balto 18, Md</u> | | Address <u>Fort Howard Div.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>154X CARCINOMA OF RECTUM WITH GENERALIZED METASTASES</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>EDEMA OF THE LUNGS</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Active fibro-caceous tuberculosis left upper lobe</u>
INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>December 15, 1959</u> to <u>December 30, 1959</u> that I last saw the deceased alive on <u>December 18, 1959</u> and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>VAH Balto 18, Md Ft Howard Div</u> DATE SIGNED _____ | | | |
| ACTUAL SIGNATURE <u>John W. Crawford</u> | | M.D. <u>VAH Balto 18, Md Ft Howard Div</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u> | | <u>VAH Balto 18, Md Ft Howard Div</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Jan 4, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S Phillips</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 5 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06251

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13408

13431

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkton</u> | | | | c. LENGTH OF STAY IN 1b
<u>life</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>York Rd. - Hereford</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Emory</u> Middle <u>Charles</u> Last <u>Leight</u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>19</u> Year <u>59</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6/4/1883</u> | | | |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>self employed</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | | | |
| 13. FATHER'S NAME
<u>Charles H. Leight</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Taylor</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>214-20-9733</u> | | 17. INFORMANT
<u>Elwood Leight</u> Address <u>above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, <u> </u> Day, <u> </u> Year <u> </u>
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town)
<u> </u> (County) <u> </u> (State) <u> </u> | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>12/1/59</u> , 19 <u> </u> , to <u>12/19/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12/10/59</u> , 19 <u> </u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>York Rd. Parkton, P.O. Hereford, Md.</u> DATE SIGNED <u>12/23/59</u> | | | | | | | | | |
| ACTUAL SIGNATURE <u>C. Herbert Mueller, Jr.</u> M.D. <u>York Rd. Parkton, P.O. Hereford, Md.</u> | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>C. Herbert Mueller, Jr., M.D.</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/22/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hereford Baptist</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Parkton, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Brooks Funeral Service, Towson 4, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 28 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Frank</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13432

CERTIFICATE OF DEATH

Reg. Dist. No.

13409

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY 2.2. ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
96 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Servedas: ALEX First D Middle D Last LIVINGSTON
ALEXANDER | | 4. DATE OF DEATH
Month December Day 29 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 20, 1893 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
B&O Railroad | 11. BIRTHPLACE (State or foreign country)
Harford Co. Maryland |
| 13. FATHER'S NAME
John G Livingston | | 14. MOTHER'S MAIDEN NAME
Katherine Bradley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
705-10-1913 | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
WW I | | INFORMANT Address
Clin. Rec. Vet Adm Hosp Balto Md Ft Howard Div. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE RIGHT HEMISPHERE
DUE TO
Canditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.
(b) _____
(c) _____
331X | | | INTERVAL BETWEEN ONSET AND DEATH
3 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Status post resection of carcinoma of the colon | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from September 24, 1959 to December 29, 1959 and that death occurred at 1:10 PM from the causes and on the date stated above.
live on September 24, 1959 and that death occurred at 1:10 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) VAH BALTO 18, MD FT HOWARD DIV DATE SIGNED 12/30/59 | | | |
| ACTUAL SIGNATURE John W. Crawford | | M.D. VAH BALTO 18, MD FT HOWARD DIV | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | VAH BALTO 18, MD FT HOWARD DIV | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/31/1959 | 22c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial Park | 22d. LOCATION (City, town, or county) (State)
Glen Burnie, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Leonard J Ruck | | 24a. REC'D BY REGISTRAR
DEC 31 '59 | 24b. REGISTRAR'S SIGNATURE
Robert S. Kraw |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1943

CERTIFICATE OF DEATH

1943

| | | | | | | | | | |
|---------------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------------|--|------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | |
| 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | |
| 11. Signature of registrar | | 12. Signature of informant | | 13. Signature of witness | | 14. Signature of funeral director | | 15. Signature of undertaker | |
| 16. Signature of health officer | | 17. Signature of coroner | | 18. Signature of jury | | 19. Signature of jury foreman | | 20. Signature of jury clerk | |
| 21. Signature of jury clerk | | 22. Signature of jury clerk | | 23. Signature of jury clerk | | 24. Signature of jury clerk | | 25. Signature of jury clerk | |
| 26. Signature of jury clerk | | 27. Signature of jury clerk | | 28. Signature of jury clerk | | 29. Signature of jury clerk | | 30. Signature of jury clerk | |
| 31. Signature of jury clerk | | 32. Signature of jury clerk | | 33. Signature of jury clerk | | 34. Signature of jury clerk | | 35. Signature of jury clerk | |
| 36. Signature of jury clerk | | 37. Signature of jury clerk | | 38. Signature of jury clerk | | 39. Signature of jury clerk | | 40. Signature of jury clerk | |
| 41. Signature of jury clerk | | 42. Signature of jury clerk | | 43. Signature of jury clerk | | 44. Signature of jury clerk | | 45. Signature of jury clerk | |
| 46. Signature of jury clerk | | 47. Signature of jury clerk | | 48. Signature of jury clerk | | 49. Signature of jury clerk | | 50. Signature of jury clerk | |
| 51. Signature of jury clerk | | 52. Signature of jury clerk | | 53. Signature of jury clerk | | 54. Signature of jury clerk | | 55. Signature of jury clerk | |
| 56. Signature of jury clerk | | 57. Signature of jury clerk | | 58. Signature of jury clerk | | 59. Signature of jury clerk | | 60. Signature of jury clerk | |
| 61. Signature of jury clerk | | 62. Signature of jury clerk | | 63. Signature of jury clerk | | 64. Signature of jury clerk | | 65. Signature of jury clerk | |
| 66. Signature of jury clerk | | 67. Signature of jury clerk | | 68. Signature of jury clerk | | 69. Signature of jury clerk | | 70. Signature of jury clerk | |
| 71. Signature of jury clerk | | 72. Signature of jury clerk | | 73. Signature of jury clerk | | 74. Signature of jury clerk | | 75. Signature of jury clerk | |
| 76. Signature of jury clerk | | 77. Signature of jury clerk | | 78. Signature of jury clerk | | 79. Signature of jury clerk | | 80. Signature of jury clerk | |
| 81. Signature of jury clerk | | 82. Signature of jury clerk | | 83. Signature of jury clerk | | 84. Signature of jury clerk | | 85. Signature of jury clerk | |
| 86. Signature of jury clerk | | 87. Signature of jury clerk | | 88. Signature of jury clerk | | 89. Signature of jury clerk | | 90. Signature of jury clerk | |
| 91. Signature of jury clerk | | 92. Signature of jury clerk | | 93. Signature of jury clerk | | 94. Signature of jury clerk | | 95. Signature of jury clerk | |
| 96. Signature of jury clerk | | 97. Signature of jury clerk | | 98. Signature of jury clerk | | 99. Signature of jury clerk | | 100. Signature of jury clerk | |

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

BP

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>31yr10mth6dys</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>SPRING GROVE STATE HOSPITAL</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Linthicum Heights, Maryland</u> | |
| f. STREET ADDRESS
<u>Linthicum Heights, Md.</u> | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Eletta</u> Middle <u>Martinol</u> Last <u>4</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>23</u> Year <u>19 59</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 30, 1888</u> |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Italy</u> ✓ | |
| 13. FATHER'S NAME
<u>Antonia Satti</u> | | 14. MOTHER'S MAIDEN NAME
<u>Olivia Vincenti</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
<u>unknown</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | |
| 17. INFORMANT
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), noting the underlying cause lost. (b) <u>GENERAL DEBILITY</u>
DUE TO (c) <u>ARTERIOSCLEROTIC VASCULAR DISEASES</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov. 29, 19 59</u> to <u>Dec. 23, 19 59</u> , that I last saw the deceased alive on <u>Dec. 23, 19 59</u> , and that death occurred at <u>5:55 A.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED
ACTUAL SIGNATURE <u>P. K. Yip</u> M.D.
PHYSICIAN'S NAME (Type) <u>P. K. Yip M.D.</u> <u>Catonsville 28, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>26 Dec. 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven</u> | 22d. LOCATION (City, town, or county) (State)
<u>Glen Burnie, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert P. Clark - Glen Burnie, Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 28 '59</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR, LAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

X-1
FOR STATE HEALTH DEPT.
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
OVERLEA | | c. LENGTH OF STAY IN life
LIFE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
7128 Greenwood Rd. | | | d. STREET ADDRESS
7128 Greenwood Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
CHRISTOPHER AUGUST MASER | | | 4. DATE OF DEATH
Month December Day 4 Year 1959 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG 23, 1915 | 9. AGE (In years last birthday)
44 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MACHINIST | | 10b. KIND OF BUSINESS OR INDUSTRY
KOPPERS COMPANY | | 11. BIRTHPLACE (State or foreign country)
BALTO MARYLAND. | |
| 13. FATHER'S NAME
JOSEPH MASER | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-09-7358 | | 17. INFORMANT
Address
MILDRED MASER 7128 GREENWOOD AVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
979X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Suffocation by plastic bag over head
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Suffocated by plastic bag over head | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour Unknown 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Baltimore Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . <u>Suicide</u> <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
W. Bradley King, Jr., M.D. | | DATE SIGNED
M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
DEC 7, 1959 | 22c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 22d. LOCATION (City, town, or country) (State)
FULLERTON MARYLAND |
| 23. FUNERAL DIRECTOR
ADDRESS
Sasseln Funeral Home 7401 Belair Road. #6. | | | 24a. REC'D BY REGISTRAR
DATE DEC 8 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline |

1951

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1951

1

1

At the place of death

Signature of physician

Signature of registrar

DEED 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9. Film G-254 1/6/60.cac.

13438

CERTIFICATE OF DEATH

13414

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND.</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>52 CATONSVILLE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>306 Ingleside Ave</u> | | e. STREET ADDRESS
<u>306 Ingleside Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>Edith</u> First <u>J. MASON</u> Middle <u>MASON</u> Last | | 4. DATE OF DEATH
<u>Dec. 27</u> 19 <u>59</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 21, 1878</u> |
| 9. AGE (In years last birthday)
<u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Thomas B. Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sallie Engler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs. Edgar D. Galvin</u> | | Address <u>5922 CHARNWOOD (28) Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1 Cardio-Respiratory Failure</u> DUE TO
(b) <u>Arteriosclerotic Hypertension of Degenerative</u> DUE TO
(c) <u>Cardiac Failure.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Nephrosclerosis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 1957</u> to <u>27 Dec 1959</u> , that I last saw the deceased alive on <u>27 Dec 1959</u> , and that death occurred at <u>12:16 M</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>William J. Bryson</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>4605 Edmondson Ave Balto 29 27 Dec 59</u> | |
| PHYSICIAN'S NAME (Type)
<u>William J. Bryson M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/30/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>LODGE PARK CEM.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>E. Truman Schwalb</u> | | ADDRESS
<u>3512 Fredenck Ave. (29)</u> | |
| 24a. REC'D BY REGISTRAR
<u>DEC 30 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanks</u> | |

CERTIFICATE OF DEATH

1937

| | | | | | |
|------------------------|--|-------------------------|--|-----------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | | DATE OF DEATH | |
| SEX | | AGE | | PLACE OF BIRTH | |
| OCCUPATION | | EDUCATION | | MARRIAGE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | |
| DATE | | TIME | | LOCATION | |
| REGISTRATION NO. | | FILE NO. | | HOSPITAL NO. | |
| CITY | | COUNTY | | STATE | |
| COUNTRY | | RACE | | RELIGION | |
| SPOUSE | | CHILDREN | | PARENTS | |
| SIBLINGS | | GRANDPARENTS | | OTHER RELATIVES | |
| FAMILY HISTORY | | SOCIAL HISTORY | | MEDICAL HISTORY | |
| PSYCHOLOGICAL HISTORY | | SUBSTANCE ABUSE HISTORY | | SURGICAL HISTORY | |
| ALLERGIC HISTORY | | IMMUNIZATION HISTORY | | PREVIOUS ILLNESSES | |
| CURRENT MEDICATIONS | | DIETARY HISTORY | | LIFESTYLE HISTORY | |
| ENVIRONMENTAL HISTORY | | TRAVEL HISTORY | | OCCUPATIONAL HISTORY | |
| LEGAL HISTORY | | FINANCIAL HISTORY | | SOCIAL HISTORY | |
| OTHER RELEVANT HISTORY | | ADDITIONAL COMMENTS | | PHYSICIAN'S COMMENTS | |
| WITNESSES' COMMENTS | | DECEASED'S COMMENTS | | FAMILY COMMENTS | |
| CITY | | COUNTY | | STATE | |
| COUNTRY | | RACE | | RELIGION | |
| SPOUSE | | CHILDREN | | PARENTS | |
| SIBLINGS | | GRANDPARENTS | | OTHER RELATIVES | |
| FAMILY HISTORY | | SOCIAL HISTORY | | MEDICAL HISTORY | |
| PSYCHOLOGICAL HISTORY | | SUBSTANCE ABUSE HISTORY | | SURGICAL HISTORY | |
| ALLERGIC HISTORY | | IMMUNIZATION HISTORY | | PREVIOUS ILLNESSES | |
| CURRENT MEDICATIONS | | DIETARY HISTORY | | LIFESTYLE HISTORY | |
| ENVIRONMENTAL HISTORY | | TRAVEL HISTORY | | OCCUPATIONAL HISTORY | |
| LEGAL HISTORY | | FINANCIAL HISTORY | | SOCIAL HISTORY | |
| OTHER RELEVANT HISTORY | | ADDITIONAL COMMENTS | | PHYSICIAN'S COMMENTS | |
| WITNESSES' COMMENTS | | DECEASED'S COMMENTS | | FAMILY COMMENTS | |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-15-2010 BY 60322 UCBAW/STP

ATTACHMENT OF
MAY 1937
15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13415

13437

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Eastwood | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3401-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7234 Conley St. # 24. | | d. STREET ADDRESS
3717 Fait Ave. # 24. | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle E. Last MAY. | | 4. DATE OF DEATH
Month December Day 30 Year 19 59. | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 18, 1888 |
| 9. AGE (In years last birthday) yrs. 71 | | IF UNDER 1 YEAR
Months 7 Days 1 Hours 4 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
House Work. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Conrad Kohles | | 14. MOTHER'S MAIDEN NAME
Barbara Hahn. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----- | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Rev. James A. May C. SS. R. | | Address
Same. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Degeneration
199.2 DUE TO metastatic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 11, 1948 to Dec. 30, 1959 that I last saw the deceased alive on Dec 28, 1959 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 3501 Fait ave. Baltimore 24 DATE SIGNED | | | |
| ACTUAL SIGNATURE
Edward A. Flanagan Jr. | | M.D. 3501 Fait ave. Baltimore 24 | |
| PHYSICIAN'S NAME (Type)
EDWARD A. FLANIGAN JR | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
1-2 -60. | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | 22d. LOCATION (City, town, or county) (State)
4430 Belair Rd., Balto., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles S. Guler | | 24a. REC'D BY REGISTRAR
JAN 5 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

IN DIRECT LINE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO PROVIDE A COMPLETE AND CORRECT RECORD OF THE DEATH OF EACH INDIVIDUAL WHO DIES IN THE STATE OF MARYLAND. THE DEPARTMENT IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE OR FOR THE RESULTS OF ANY ACTION TAKEN THEREON. THE DEPARTMENT IS NOT A COURT OF RECORD AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF APPEALS AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF REVISION AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF ERROR AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF SURETY AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF RECORD AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF APPEALS AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF REVISION AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF ERROR AND ITS DECISIONS ARE NOT FINAL. THE DEPARTMENT IS NOT A COURT OF SURETY AND ITS DECISIONS ARE NOT FINAL.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13416

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MARYLAND COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
363 SAVANNAH AVE | | d. STREET ADDRESS
363 SAVANNAH AVE | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle A Last MAYES | | 4. DATE OF DEATH
Month 12 Day 31 Year 1957 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 16-1892 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
PINEHILL-NEW YORK | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
CHARLES ROSA | | 14. MOTHER'S MAIDEN NAME
LILLIAN BALDWIN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
ANTHONY MAYES Address (SAME AS ABOVE) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b) arter. Sclerotic Heart Dis.
DUE TO
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
16 yrs
20 yrs | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
Jack C Collins | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
JACK C COLLINS | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 22b. DATE THEREOF
1-1-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
WOODSTOCK CEM. | | 22d. LOCATION (City, town, or county) (State)
WOODSTOCK NEW YORK | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Connolly | | ADDRESS
418 Eastern Ave BALTO | |
| 24a. REC'D BY REGISTRAR
JAN 4 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Haines | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13417

13435

| | | | | | |
|--|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Balto</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural-Freeland</u> | | c. LENGTH OF STAY IN 1b
<u>5 min.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural-Hampstead</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Beckleysville Rd.</u> | | | d. STREET ADDRESS
<u>Beckleysville</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>Albert Lee Mays</u> | | | 4. DATE OF DEATH <u>Dec. 7</u> , 19 <u>59</u> | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 31, 1945</u> | | 9. AGE (In years last birthday)
<u>14</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>School</u> | 11. BIRTHPLACE (State or foreign country)
<u>Hampstead Md.</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Albert L. Mays</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Melvia Bull</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | 17. INFORMANT
<u>Albert L. Mays, Hampstead, Md. R.D.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Compound fracture of the skull</u>
819X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>Instant</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Automobile struck a bridge abutment.</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>10.30 p. m. Dec. 8 1959</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Highway</u> | 20f. (City or town)
<u>Beckleysville, Balto., Md.</u> | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<u>A. M. France</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
<u>12/8/59</u> | |
| EXAMINER'S NAME (Type)
<u>A. M. France</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>12/10/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Beckleysville Cemetery</u> | | 22d. LOCATION (City, town or county)
<u>Hampstead Md. R.D.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jacob Horstenstein</u> | | ADDRESS
<u>New Freedom Pa.</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 14 '59</u> | 24b. REGISTRAR'S SIGNATURE
<u>Robert S. France</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13418

13440

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> | | c. LENGTH OF STAY IN 1b <u>5 min.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beckleysville Rd.</u> | | d. STREET ADDRESS <u>Beckleysville.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Rosemary A. Mays</u> | | 4. DATE OF DEATH <u>Dec. 7</u> 19 <u>59</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Febr. 23, 1942</u> 17 yrs. |
| 9. AGE (In years last birthday) <u>17</u> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u> | 11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Albert L. Mays</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Melvia Bull</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Albert L. Mays</u> Address <u>Hampstead Md. R.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture of the skull</u>
819X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u>
DUE TO (c) <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>
INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck a bridge abutment.</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>10.30 p.m. Dec. 7 19 59</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | | 20f. (City or town) <u>Beckleysville, Balto., Md.</u> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>A. M. France</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>Dec. 8, 1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/10/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Beckleysville Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Hampstead Md. R.D.</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Doak Hartenstein</u> | | ADDRESS <u>New Freedom Pa.</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 14 59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

1
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 12-24-60

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. PREVIOUS MARRIAGES: _____

9. EDUCATION: _____

10. RELIGION: _____

11. RACE: _____

12. COLOR: _____

13. ETHNIC ORIGIN: _____

14. SOCIAL SECURITY NUMBER: _____

15. HOME ADDRESS: _____

16. PHONE NUMBER: _____

17. DATE OF DEATH: _____

18. TIME OF DEATH: _____

19. PLACE OF DEATH: _____

20. CAUSE OF DEATH: _____

21. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

22. SIGNATURE OF MEDICAL EXAMINER: _____

23. SIGNATURE OF WITNESS: _____

24. SIGNATURE OF DECEASED: _____

25. SIGNATURE OF NEXT OF KIN: _____

26. SIGNATURE OF CLERK: _____

27. SIGNATURE OF JURY: _____

28. SIGNATURE OF JUDGE: _____

29. SIGNATURE OF DISTRICT ATTORNEY: _____

30. SIGNATURE OF COUNTY CLERK: _____

31. SIGNATURE OF CITY CLERK: _____

32. SIGNATURE OF TOWNSHIP CLERK: _____

33. SIGNATURE OF VILLAGE CLERK: _____

34. SIGNATURE OF POST OFFICE CLERK: _____

35. SIGNATURE OF SCHOOL CLERK: _____

36. SIGNATURE OF CHURCH CLERK: _____

37. SIGNATURE OF SYNAGOGUE CLERK: _____

38. SIGNATURE OF MOSQUE CLERK: _____

39. SIGNATURE OF TEMPLE CLERK: _____

40. SIGNATURE OF OTHER CLERK: _____

13441
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | | | c. LENGTH OF STAY IN 1b
<u>20 YRS.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>SPRING GROVE STATE HOSP.</u> | | | | d. STREET ADDRESS
<u>RFD #1</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>LEONARD</u> First Middle Last <u>McGOWAN</u> | | | | 4. DATE OF DEATH
Month <u>DECEMBER</u> Day <u>15</u> Year <u>1959</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/22/1900</u> | 9. AGE (In years last birthday)
<u>59</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FARM LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JAMES McGOWAN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARTHA HONES</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>UNK.</u> | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
<u>S.G.S.H. RECORDS</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>SUDDEN CARDIAC ARREST</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROBABLE CORONARY OCCLUSION</u>
(c) <u>None - DEATH SUDDEN</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>CENTRAL NERVOUS SYSTEM SYPHILLIS</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>59</u> , to <u>12/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>59</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSP</u> DATE SIGNED <u>12/15/59</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Anthony S. Garofano</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>ANTHONY S. GAROFANO</u> <u>CATONSVILLE, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
<u>1-20-60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>U. of Md. Med. School</u> | | 22d. LOCATION (City, town, or county) | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Anthony S. Garofano</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 25 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20521

13442
CERTIFICATE OF DEATH

Reg. Dist. No.

13419

| | | | | | | | |
|---|--------------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
6yrlmth23dys | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
1006 S. Caroline - S. E. | | | |
| 3. NAME OF DECEASED (Type or print)
First George Middle Sipe Last McKnight | | | | 4. DATE OF DEATH
Month December Day 21 Year 1959 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 5, 1905 | 9. AGE (In years last birthday)
54 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
cargo packer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
George McKnight | | | | 14. MOTHER'S MAIDEN NAME
Mary ? Sipe | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown No | | 16. SOCIAL SECURITY NO.
578-30-7664 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized carcinomatosis
DUE TO Adenocarcinoma of the sigmoid.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | Month, Day, Year | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from Sept. 24 , 19 59 , to Dec. 21 , 19 59 , that I last saw the deceased alive on Dec. 21 , 19 59 , and that death occurred at 10:55a M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-21-59
ACTUAL SIGNATURE Stelb Wachslar M.D.
PHYSICIAN'S NAME (Type) Stelb Wachslar, M. D. Catonsville 28, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-23-59 | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Bladensburg, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. W. Chambers Co Inc | | | | ADDRESS
517-11th St SE | | 24a. REC'D BY REGISTRAR
DATE DEC 24 '59 | 24b. REGISTRAR'S SIGNATURE
Charles E. Hume |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13443

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY MARYLAND ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
COCKEYSVILLE | | | | c. LENGTH OF STAY IN 1b
5 YEARS + 9 MO. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MASONIC HOME | | | | d. STREET ADDRESS
105 UPNOR RD. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
IRENE E METTEE | | | | 4. DATE OF DEATH
Month Day Year
DEC 25 1959 | | | |
| 5. SEX
FE | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-27-1876 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | | |
| 13. FATHER'S NAME
THOMAS GIFFORD | | | | 14. MOTHER'S MAIDEN NAME
IRENE STEVENS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Frank L. Smith Address Cockeysville, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 years. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-27-1954 , to 12-23-1959 , that I last saw the deceased alive on 12-23-1959 , and that death occurred at 6:40 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cockeysville, Md DATE SIGNED 12/25/59
ACTUAL SIGNATURE William J. Cook M.D.
PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
12-28-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Woodlawn, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Cook, Inc., 1217 S. Paul Street | | | | 24a. REC'D BY REGISTRAR
DATE DEC 28 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------|--|--------------------------|--|----------------------------|--|--------------------------|--|-------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | |
| 6. OCCUPATION | | 7. MARITAL STATUS | | 8. RACE | | 9. ETHNIC ORIGIN | | 10. RELIGION | |
| 11. DATE OF DEATH | | 12. TIME OF DEATH | | 13. PLACE OF DEATH | | 14. CAUSE OF DEATH | | 15. MANNER OF DEATH | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF PHYSICIAN | | 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF JUDGE | |
| 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF WITNESS | | 23. SIGNATURE OF PHYSICIAN | | 24. SIGNATURE OF CORONER | | 25. SIGNATURE OF JUDGE | |
| 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF WITNESS | | 28. SIGNATURE OF PHYSICIAN | | 29. SIGNATURE OF CORONER | | 30. SIGNATURE OF JUDGE | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF WITNESS | | 33. SIGNATURE OF PHYSICIAN | | 34. SIGNATURE OF CORONER | | 35. SIGNATURE OF JUDGE | |
| 36. SIGNATURE OF DECEASED | | 37. SIGNATURE OF WITNESS | | 38. SIGNATURE OF PHYSICIAN | | 39. SIGNATURE OF CORONER | | 40. SIGNATURE OF JUDGE | |
| 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF WITNESS | | 43. SIGNATURE OF PHYSICIAN | | 44. SIGNATURE OF CORONER | | 45. SIGNATURE OF JUDGE | |
| 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF WITNESS | | 48. SIGNATURE OF PHYSICIAN | | 49. SIGNATURE OF CORONER | | 50. SIGNATURE OF JUDGE | |
| 51. SIGNATURE OF DECEASED | | 52. SIGNATURE OF WITNESS | | 53. SIGNATURE OF PHYSICIAN | | 54. SIGNATURE OF CORONER | | 55. SIGNATURE OF JUDGE | |
| 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF WITNESS | | 58. SIGNATURE OF PHYSICIAN | | 59. SIGNATURE OF CORONER | | 60. SIGNATURE OF JUDGE | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF WITNESS | | 63. SIGNATURE OF PHYSICIAN | | 64. SIGNATURE OF CORONER | | 65. SIGNATURE OF JUDGE | |
| 66. SIGNATURE OF DECEASED | | 67. SIGNATURE OF WITNESS | | 68. SIGNATURE OF PHYSICIAN | | 69. SIGNATURE OF CORONER | | 70. SIGNATURE OF JUDGE | |
| 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF WITNESS | | 73. SIGNATURE OF PHYSICIAN | | 74. SIGNATURE OF CORONER | | 75. SIGNATURE OF JUDGE | |
| 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF WITNESS | | 78. SIGNATURE OF PHYSICIAN | | 79. SIGNATURE OF CORONER | | 80. SIGNATURE OF JUDGE | |
| 81. SIGNATURE OF DECEASED | | 82. SIGNATURE OF WITNESS | | 83. SIGNATURE OF PHYSICIAN | | 84. SIGNATURE OF CORONER | | 85. SIGNATURE OF JUDGE | |
| 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF WITNESS | | 88. SIGNATURE OF PHYSICIAN | | 89. SIGNATURE OF CORONER | | 90. SIGNATURE OF JUDGE | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF WITNESS | | 93. SIGNATURE OF PHYSICIAN | | 94. SIGNATURE OF CORONER | | 95. SIGNATURE OF JUDGE | |
| 96. SIGNATURE OF DECEASED | | 97. SIGNATURE OF WITNESS | | 98. SIGNATURE OF PHYSICIAN | | 99. SIGNATURE OF CORONER | | 100. SIGNATURE OF JUDGE | |

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Births and Deaths, and that the same has been duly examined and found correct.

Registrar of Births and Deaths

Date: _____

Place: _____

13444

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
126 Pleasant Hill Rd. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HERBERT Middle C. Last MILES | | | | 4. DATE OF DEATH
Month Dec. Day 1 Year 19 59 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 4, 1899 | | 9. AGE (In years last birthday)
60 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Transit | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
David Miles | | | | 14. MOTHER'S MAIDEN NAME
Carrie Young | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
- | | INFORMANT
Mrs. Blanche Miles - 126 Pleasant Hill Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO
(c) Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 minute
5 yrs
5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Coronary insufficiency | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-1- , 19 40 , to 12-1- 59 , that I last saw the deceased alive on 10-5- 59 , and that death occurred at 10:30 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James G. Saffell M.D. | | | | ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 12-1-59 | | | |
| PHYSICIAN'S NAME (Type) James G. Saffell M.D. | | | | Reisterstown Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/1/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Lorraine Cem. | | 22d. LOCATION (City, town, or county) (State)
Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Vickner & Sons - Balto. | | | | 24a. REC'D BY REGISTRAR
DATE DEC 3 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13422

Reg. Dist. No.

13443

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY <i>Balto</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6826 Navajo Drive</i> | | d. STREET ADDRESS <i>6826 Navajo Drive</i> | |
| 3. NAME OF DECEASED (Type or print) <i>FANNIE MILLER</i> | | 4. DATE OF DEATH
Month <i>12</i> - Day <i>9</i> - Year <i>1959</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) <i>63</i> yrs. | | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Samuel</i> | | 14. MOTHER'S MAIDEN NAME <i>Minnie</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Stanley Miller</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral metastases</i>
<i>175.0</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma, ovary?</i>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 months?</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Metastases to lung & pleura</i> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>5/26</i> , 19 <i>59</i> , to <i>12-10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-2</i> , 19 <i>59</i> , and that death occurred at <i>12-10</i> , 19 <i>59</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Stanley R. Steinbach</i> | | ADDRESS (Street, city or town, state) <i>3334 Dorfield Ave</i> | |
| PHYSICIAN'S NAME (Type) <i>Stanley R. Steinbach</i> | | DATE SIGNED <i>12/10/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>12-19-59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>City of Charm</i> | 22d. LOCATION (City, town, or county) (State) <i>Balto Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Evers Inc</i> | | ADDRESS <i>2100 Euterio Place</i> | |
| 24a. REC'D BY REGISTRAR <i>DEC 11 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13423**

1
FOR STATE
HEALTH DEPT.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point, 19, Md. | | c. LENGTH OF STAY IN 1b 3001-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John W. Miller | | 4. DATE OF DEATH
Month 12 Day 21 Year 1959 | |
| 5. SEX M | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-31-1931 |
| 9. AGE (In years last birthday) 28 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer Helper | 11. BIRTHPLACE (State or foreign country) Virginia |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | 13. FATHER'S NAME John Miller | |
| 14. MOTHER'S MAIDEN NAME Lottie Rose | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. 226-32-7273 | | 17. INFORMANT Address Mrs. Rosa May Miller 812 N. Washington St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Myocardial Infarction
 420.1 DUE TO Coronary Thrombosis.
 Conditions, if any, which gave rise to immediate cause (b) _____
 (a), stating the underlying cause last. (c) _____ </div> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20b. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20d. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Petty | | DATE SIGNED 12/22/59 | |
| EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 12-24-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery | | 22d. LOCATION (City, town, or county) (State) Nutbush, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick | | 24. REC'D BY REGISTRAR DEC 28 '59 | |
| ADDRESS 1412 E. Preston St. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kram | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1912

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH OFF.

1912



FACE OF CERTIFICATE

1. NAME OF DECEASED: _____
2. SEX: ☐ Male ☐ Female
3. AGE: _____
4. OCCUPATION: _____
5. PLACE OF BIRTH: _____
6. DATE OF DEATH: _____
7. TIME OF DEATH: _____
8. CAUSE OF DEATH: _____
9. MANNER OF DEATH: _____
10. SIGNATURE OF EXAMINER: _____
11. SIGNATURE OF WITNESS: _____
12. SIGNATURE OF JURY: _____
13. SIGNATURE OF CORONER: _____
14. SIGNATURE OF MINISTER OF THE GOSPEL: _____
15. SIGNATURE OF CHURCH WARDEN: _____
16. SIGNATURE OF RING-BEARER: _____
17. SIGNATURE OF BEST MAN: _____
18. SIGNATURE OF U.S. MARSHAL: _____
19. SIGNATURE OF CLERK: _____
20. SIGNATURE OF SHERIFF: _____
21. SIGNATURE OF JAILER: _____
22. SIGNATURE OF PRISON WARDEN: _____
23. SIGNATURE OF COUNTY CLERK: _____
24. SIGNATURE OF CITY CLERK: _____
25. SIGNATURE OF STATE CLERK: _____

13447

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fullerton Nursing Home 8409 Belair Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Selvia Middle C. Last Miller | | 4. DATE OF DEATH Month December Day 8 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 23, 1878 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Scott | | 14. MOTHER'S MAIDEN NAME Nancy Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mr. James E. Miller | | Address 4206 Parkside Drive | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ARTERIOCHEROSIS, GENERALIZED
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
2 YEARS
20 YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 18, 1958 to December 5, 1959 , that I last saw the deceased alive on Dec. 5, 1959 , and that death occurred at LA. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Adam G. Swiss | | ADDRESS (Street, city or town, state) 6232 BELAIR RD. BALTIMORE, MD. | |
| PHYSICIAN'S NAME (Type) ADAM G. SWISS | | DATE SIGNED DEC 9, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Dec. 11, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home | | ADDRESS 7401 Belair Rd. | |
| 24a. REC'D BY REGISTRAR DEC 11 59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

090

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Name of physician

11. Name of funeral director

12. Name of informant

13. Name of registrar

14. Name of witness

15. Name of witness

16. Name of witness

17. Name of witness

18. Name of witness

19. Name of witness

20. Name of witness

CERTIFICATE OF DEATH

13425

Reg. Dist. No.

13448

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls Balto. Co.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sunshine Ave</u> | | d. STREET ADDRESS <u>1 Sunshine Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>B. Monmonier</u> Last | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 1 1866</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractor Ret.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Charles G. Monmonier</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Armstrong</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Rev Charles B. Monmonier</u> | | Address <u>1410 Riverside Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
421.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u>
DUE TO
(c) <u>Chronic endocarditis & myocarditis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>1 yr. +</u>
<u>7 yr. +</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Parotitis - St. cerebral thrombosis & facial weakness</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>July 1, 1953</u> to <u>Dec. 18, 1959</u> , that I last saw the deceased alive on <u>Dec. 18, 1959</u> , and that death occurred at <u>9:15 p. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Isabel H. McClinton M.D.</u> | | ADDRESS (Street, city or town, state) <u>Bel Air Rd., Kingsville, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Isabel H. McClinton, M.D.</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Dec 22-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Upper Falls Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Suppel Bros. 7110 Belair Rd. 6</u> | | 24a. REC'D BY REGISTRAR <u>DEC 22 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1955

CERTIFICATE OF DEATH

1955

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 2 Film G254 1-11-60 et
 13449
 CERTIFICATE OF DEATH

13426

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore A.A.Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore/ Greenland Beach 02x-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Summit Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Charles Eugene Mounts | | | | 4. DATE OF DEATH
Month Day Year
Dec. 31, 1959 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 8, 1887 | | 9. AGE (In years last birthday) yrs.
72 | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Council Bluff, Iowa | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | 13. FATHER'S NAME
Unknown | | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W. I in none | | | |
| 16. SOCIAL SECURITY NO.
in none | | | | 17. INFORMANT
Edgar C. Powers 9 E. Franklin Street | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331x DUE TO Multiple Cerebral/Vascular Accidents
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from 54 12/31/59 to 12/30/59 8:35 A.M. from the causes and on the date stated above. | | | |
| 21. I certify that I attended the deceased from 12/30/59 and that death occurred 12/31/59 M. from the causes and on the date stated above. | | | | 22. ADDRESS (Street, city or town, state) DATE SIGNED
1303 Frederick Rd (28) 1/2/60 | | | |
| ACTUAL SIGNATURE
W. E. McGrath | | | | M.D. 1303 Frederick Rd | | | |
| PHYSICIAN'S NAME (Type)
EXR. W. E. McGrath, M. D. | | | | 1303 Frederick Road | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
1/4/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | | | ADDRESS
4107 Wilkens Avenue | | 24a. REC'D BY REGISTRAR
JAN 4 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Knaus | | | | | | | |

CERTIFICATE OF DEATH

Baltimore

Baltimore

Summit Nursing Home

Summit Nursing Home

Charles

Robert

Dec. 31

59

Male

White

June 8, 1907

Retired

Council Bluffs, Iowa U. S. A.

Unknown

Unknown

Yes

U. S. I

in none

Robert C. Powers 2 E. Franklin Street

Robert C. Powers, M. D. 1303 Frederick Road

Burial

Baltimore National Cem. Baltimore, Maryland

Robert C. Powers 1107 Wilkins Avenue

CERTIFICATE OF DEATH

Reg. Dist. No.

13427

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Darlington</u> COUNTY <u>Harford</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Md</u> 12 X - 2 | |
| 3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u> | | 4. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Allen L. Moxley</u> First Middle Last | | 4. DATE OF DEATH <u>Dec. 2, 1959</u> Month Day Year | |
| 5. SEX <u>Male</u> COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 15, 1871</u> Yrs. Months Days Hours Min. | 9. AGE (In years) <u>88</u> Yrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Cattle Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Allegany Co., W. Va.</u> | |
| 11. CITIZENSHIP (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Alfred Moxley</u> | | 14. MOTHER'S MAIDEN NAME <u>Hallie Palmer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Mr. Mrs. Maxine Goodman</u> Address <u>Rising Sun, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>422.1 Decompensative Cardiovascular Disease</u>
DUE TO (b) <u>Arteriosclerosis</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 10, 1958</u> to <u>Dec. 2, 1959</u> that I last saw the deceased alive on <u>Dec. 2, 1959</u> and that death occurred at <u>12:45 PM</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Laurence C. Post</u> | | ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore 12 Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u> | | DATE SIGNED <u>12/2/59</u> | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Dec. 7, 1959</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wytheville</u> | | 22d. LOCATION (City, town, or county) (State) <u>Ta.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Darlington Md</u> | | 24a. READ BY REGISTRAR DATE <u>DEC 8 '59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13428

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b
53 Dundalk | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
7455 German Hill Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Charles S Napiraski | | 4. DATE OF DEATH
Month 12 / Day 24 / Year 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 6 1893 |
| 9. AGE (In years last birthday)
66 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
gardner ret | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Anton Napiraski | | 14. MOTHER'S MAIDEN NAME
Constance Dardes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) yes WW L | | 16. SOCIAL SECURITY NO.
212 32 2459 A | |
| 17. INFORMANT
Mrs Frances Armstrong | | Address
6540 Parnell Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO A-S-C-V Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
7 = | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
No | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
M. B. Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
M. B. DAVIS M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
12/28/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
12/28/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 22d. LOCATION (City, town, or county) (State)
German Hill Road | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home | | ADDRESS
2112 Dundalk Ave | |
| 24a. REC'D BY REGISTRAR
DEC 30 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G254 12-30-59 et

13451

CERTIFICATE OF DEATH

Reg. Dist. No.

13429

32

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HOWARD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson | | | | c. LENGTH OF STAY IN 1b
10 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | | | d. STREET ADDRESS
EDLAND FARM 18X-2 | | | |
| 3. NAME OF DECEASED (Type or print) JOSEPH First JULIUS Middle OLSZEWSKI Last | | | | 4. DATE OF DEATH
Month 12 - Day 17 - Year 1959 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Unknown DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-15-1900 | |
| 9. AGE (In years last birthday) 59 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
? | |
| 13. FATHER'S NAME
NICHOLAS OLZEWSKI | | | | 14. MOTHER'S MAIDEN NAME
ELVANINA ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
217-05-6859 | | | |
| 17. INFORMANT
Hospital Records, Mt. Wilson State Hospital | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
ONE MONTH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from 12-7- , 1959 , to 12-17- , 1959 , that I last saw the deceased alive on 12-16- , 1959 , and that death occurred at 7:15 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE _____ M.D. Mt. Wilson, Maryland | | | | | | | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | Superintendent | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 12-22-59 | | St. Peter | | Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James H. Newcomb, Pikes & | | | | 24a. REC'D BY REGISTRAR
DATE DEC 23 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the a' page 3 should be detached for use as the burial-transit permit. the registrar prior to burial, cremation, or removal, and is

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13452
CERTIFICATE OF DEATH

13430

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTO | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ROSEDALE. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X ROSEDALE. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
8414 PHILADELPHIA ROAD. | | | | d. STREET ADDRESS
18414 PHILADELPHIA ROAD. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
HERBERT F OTTO | | | | 4. DATE OF DEATH Month Day Year
DEC 15 1959 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG 28, 1888 | 9. AGE (In years lost birthday)
71 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ASSEMBLYMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
ANCHOR POST | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
OSCAR OTTO | | | | 14. MOTHER'S MAIDEN NAME
ANNIE RAUSCH. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-03-3298 | | INFORMANT Address
MRS WILHELMINA OTTO 8414 PHILA ROAD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.1 DUE TO coronary sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary insufficiency
(c) arterio sclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus (Controlled Carburelle diet) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1, 1959 to Dec 15, 1959 , that I last saw the deceased alive on Dec 15, 1959 , and that death occurred at 11:15 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Walter A. Anderson M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
3001 SHANNON DRIVE BALTO. 13 MD. | | | |
| PHYSICIAN'S NAME (Type) DR WALTER A. ANDERSON | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
DEC 18, 1959. | | 22c. NAME OF CEMETERY OR CREMATORY
BALTIMORE | | 22d. LOCATION (City, town, or county) (State)
BALTIMORE CO. MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Janssah. Funeral Home | | | | ADDRESS
7401 BELAIR Rd. #6 | | 24a. REC'D BY REGISTRAR
DEC 21 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

MEDICAL CERTIFICATION

Attending physician and completely filled in by the funeral director, Then please remove carbon papers. Pages 1 and 2 should be filled with any event within 72 hours after death.

15130

15130

OFFICE OF THE SECRETARY OF THE ARMY

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JAN 10 1921

13453

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
64 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle J. Last PAAR SR. SR. | | 4. DATE OF DEATH
Month DECEMBER Day 25 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/11/97 |
| 9. AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Gas Station Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Gas Station | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ferdinand Paar | | 14. MOTHER'S MAIDEN NAME
Emma Leifert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
220-12-4987 | |
| 17. INFORMANT
Clin. Rec. VA Hosp, Balto. Md. Ft. Howard Division | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH METASTASIS TO HILAR LYMPH NODES AND LIVER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS
(c) OLD MYOCARDIAL INFARCTION | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. VA 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 22, 1959 to December 25, 1959 , and that death occurred at 10:15 AM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Walter C. Goldstein, M.D. | | ADDRESS (Street, city or town, state) VAH, BALTO. MD. FT. HOWARD DIVISION | |
| PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D. | | DATE SIGNED 12/25/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec 25, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Louden Park Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
A. Howard Evans Funeral Home, Baltimore, Maryland | | 24a. REC'D BY REGISTRAR
DEC 28 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|---|--|-------------------------------|--|--|---|---|---|--|--|----------------------------------|
| 13454 | | | | | CERTIFICATE OF DEATH | | | | | |
| Reg. Dist. No. 13432 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WYCOMICO | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS, MD | | | | | c. LENGTH OF STAY IN 1b 4 DAYS | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TR. SCHOOL | | | | | d. STREET ADDRESS 407 CLAYBOURNE ST. | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARIE DOREEN PALMER | | | | | 4. DATE OF DEATH Month Day Year 12 27 1959 | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MARCH 28, 1959 | | 9. AGE (In years lost birthday) yrs. Months Days Hours Min. 9 7 - - | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME KENNETH PALMER | | | | | 14. MOTHER'S MAIDEN NAME ZELLINE CROCKETT | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | | | | 16. SOCIAL SECURITY NO. INFORMANT Address ROSEWOOD RECORDS | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 490X Bilateral pneumonia, acute and chronic with bilateral otitis media
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 12/23 , 19 59 to 12/27 , 19 59 that I last saw the deceased alive on 12/27 , 19 59 , and that death occurred at 11:20 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore 14, Md. DATE SIGNED 12-27-59
ACTUAL SIGNATURE Peter W. Rieckert
PHYSICIAN'S NAME (Type) Peter W. Rieckert | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 22b. DATE THEREOF 12/30/59 | | 22c. NAME OF CEMETERY OR CREMATORY quantico | | 22d. LOCATION (City, town, or county) (State) quantico Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Clinton O. Stewart ADDRESS Salisbury Md. | | | | | 24a. REC'D BY REGISTRAR JAN 4 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

2082215XUG

2384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13433

13455

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>316 Murdock Road</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>R.</i> Last <i>Parlett</i> | | 4. DATE OF DEATH Month <i>December</i> Day <i>26</i> Year <i>1959</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>August 2, 1879</i> |
| 9. AGE (In years (last birthday) yrs. <i>80</i>) | | IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore County</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Edward Maddox</i> | | 14. MOTHER'S MAIDEN NAME <i>Frances Hughes</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>none</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | |
| 17. INFORMANT Address <i>Mrs Ruth E. Neisser 316 Murdock Road</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of Descending Colon</i>
<i>153.2</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>153.2</i> DUE TO (c) <i>153.2</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>June 5, 1954</i> , to <i>Dec. 26, 1959</i> , that I last saw the deceased alive on <i>Dec. 26, 1959</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Laurence C. Post</i> M.D. <i>6805 York Rd.</i> | | DATE SIGNED <i>12/29/59</i> | |
| PHYSICIAN'S NAME (Type) <i>LAURENCE C. Post</i> | | <i>Baltimore</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Dec 30, 1959</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Baltimore Street</i> | | 24a. REC'D BY REGISTRAR <i>DEC 31 59</i> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kraus</i> | |

CERTIFICATE OF DEATH

| | | | |
|----------------------|--|------------------------------|--|
| DATE OF DEATH | | PLACE OF DEATH | |
| 1943 | | BALTIMORE | |
| TIME OF DEATH | | CAUSE OF DEATH | |
| 10:00 AM | | HEART DISEASE | |
| AGE | | SEX | |
| 65 | | M | |
| RACE | | RELIGION | |
| WHITE | | METHODIST | |
| BIRTH DATE | | BIRTH PLACE | |
| 1878 | | BALTIMORE | |
| MARRIAGE | | EDUCATION | |
| MARRIED | | HIGH SCHOOL | |
| OCCUPATION | | PREVIOUS ILLNESS | |
| RETIRED | | NONE | |
| DATE OF LAST ILLNESS | | DATE OF LAST PHYSICIAN VISIT | |
| 1943 | | 1943 | |
| NAME OF PHYSICIAN | | NAME OF HOSPITAL | |
| DR. J. H. SMITH | | BALTIMORE HOSPITAL | |
| NAME OF FUNERAL HOME | | NAME OF BURIAL PLACE | |
| JOHN J. SMITH | | BALTIMORE CEMETERY | |
| DATE OF BURIAL | | SIGNATURE OF DECEASED | |
| 1943 | | [Signature] | |
| DATE OF CERTIFICATE | | SIGNATURE OF REGISTRAR | |
| 1943 | | [Signature] | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13456

CERTIFICATE OF DEATH

13434

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
1yr 6m 11dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Mamie Parsons | | 4. DATE OF DEATH
Month Day Year
Dec. 23 1959 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> | 8. DATE OF BIRTH
May 22, 1892 |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 11. BIRTHPLACE (State or foreign country)
Alabama | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Elizabeth ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart disease long standing
(c) generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs
7:11 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
arterial hypertension | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 22 , 19 59 , to Dec 23 , 19 59 , that I last saw the deceased alive on Dec 23 , 19 59 , and that death occurred at 7:50 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Bruno Radauskas | | ADDRESS (Street, city or town, state)
SPRING GROVE STATE HOSPITAL | |
| PHYSICIAN'S NAME (Type)
BRUNO RADAUSKAS | | DATE SIGNED
12/23/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-26-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 22d. LOCATION (City, town, or county) (State)
Glen Burnie, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John F. Lerry, Inc. Balto. 30 Md. | | 24a. REC'D BY REGISTRAR
DEC 28 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13457

CERTIFICATE OF DEATH

13435

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jones Creek | | c. LENGTH OF STAY IN 1b
6 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Residence, 7347 Waldman Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First William Middle E. Last Patterson | | 4. DATE OF DEATH
Month December Day 23 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 26, 1907 |
| 9. AGE (In years last birthday)
52 yrs. | | IF UNDER 1 YEAR
Months 52 Days 52 Hours 52 Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel Co. | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas Patterson | | 14. MOTHER'S MAIDEN NAME
Mary Pennington | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Yes Army WWII | | 16. SOCIAL SECURITY NO.
236-07-7254 | |
| 17. INFORMANT
Mrs. Etta (Elizabeth) Patterson | | Address
7347 Waldman Ave. 19, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Lung
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
8 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 59 , to Dec. 23 , 19 59 , that I last saw the deceased alive on Dec 23 , 19 59 , and that death occurred at 10:15 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Leon E. Kassel | | ADDRESS (Street, city or town, state) DATE SIGNED
3501 St Paul Street Beth Md 12/24/59 | |
| PHYSICIAN'S NAME (Type)
Leon E. Kassel, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Dec. 27, 1959 | 22c. NAME OF CEMETERY OR CREMATORY
Athens Cemetery | 22d. LOCATION (City, town, or county) (State)
Athens, West Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Duda | | ADDRESS
7922 Wise Ave. 22, Md. | |
| 24a. REC'D BY REGISTRAR
DATE DEC 29 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| <p>1. NAME OF DECEASED
 [REDACTED]</p> | | <p>2. SEX
 [REDACTED]</p> | | <p>3. AGE
 [REDACTED]</p> | |
| <p>4. DATE OF DEATH
 [REDACTED]</p> | | <p>5. TIME OF DEATH
 [REDACTED]</p> | | <p>6. PLACE OF DEATH
 [REDACTED]</p> | |
| <p>7. OCCUPATION
 [REDACTED]</p> | | <p>8. CAUSE OF DEATH
 [REDACTED]</p> | | <p>9. MANNER OF DEATH
 [REDACTED]</p> | |
| <p>10. SIGNATURE OF PHYSICIAN
 [REDACTED]</p> | | <p>11. SIGNATURE OF REGISTRAR
 [REDACTED]</p> | | <p>12. SIGNATURE OF WITNESS
 [REDACTED]</p> | |
| <p>13. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>14. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>15. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>16. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>17. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>18. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>19. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>20. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>21. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>22. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>23. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>24. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>25. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>26. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>27. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>28. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>29. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>30. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>31. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>32. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>33. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>34. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>35. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>36. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>37. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>38. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>39. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>40. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>41. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>42. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>43. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>44. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>45. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>46. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>47. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>48. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>49. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>50. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>51. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>52. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>53. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>54. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>55. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>56. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>57. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>58. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>59. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>60. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>61. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>62. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>63. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>64. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>65. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>66. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>67. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>68. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>69. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>70. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>71. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>72. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>73. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>74. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>75. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>76. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>77. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>78. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>79. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>80. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>81. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>82. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>83. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>84. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>85. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>86. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>87. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>88. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>89. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>90. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>91. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>92. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>93. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>94. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>95. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>96. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>97. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>98. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>99. SIGNATURE OF OTHER
 [REDACTED]</p> | |
| <p>100. SIGNATURE OF DECEASED
 [REDACTED]</p> | | <p>101. SIGNATURE OF NEXT OF KIN
 [REDACTED]</p> | | <p>102. SIGNATURE OF OTHER
 [REDACTED]</p> | |

18

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE LOANED OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE TERM FOR WHICH IT WAS ISSUED.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13458

CERTIFICATE OF DEATH

Reg. Dist. No. 32

13436

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTO. ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 15 Md. 3Y01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | d. STREET ADDRESS
2928 BOARMAN AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MELCHOR Middle WINFIELD Last PEREGUY | | 4. DATE OF DEATH
Month 12 Day 18 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-11-1879 |
| 9. AGE (In years lost birthday) 80 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MOTORMAN | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
BALTO. MD. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
STOPHEL PEREGUY | |
| 14. MOTHER'S MAIDEN NAME
SARAH BULL | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
213-10-0912 | | 17. INFORMANT
Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS
DUE TO (b) 3 months
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
ARTERIOSCLEROSIS, BLADDER NECK CONTRACTURE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-28 , 19 59 , to 12-18 , 19 59 , that I last saw the deceased alive on 12-18 , 19 59 , and that death occurred at 9:10 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED | | | |
| ACTUAL SIGNATURE
William Newcomer | | M.D. Mt. Wilson, Maryland | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | Superintendent | |
| 22a. BURIAL, CREMATION REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-18-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Foreston Cemetery | | 22d. LOCATION (City, town, or county) (State)
Foreston, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frank H. Newell, Pikesville, Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
DEC 30 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13459

CERTIFICATE OF DEATH

Reg. Dist. No.

13437

| | | | | | | | |
|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
5yrlmth22dys | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
California, Maryland | | | | 18x-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Caroline Middle N. Last Perry | | | | 4. DATE OF DEATH
Month December Day 15 Year 19 59 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 30, 1897? | 9. AGE (In years last birthday)
62? | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
James | | | | 14. MOTHER'S MAIDEN NAME
Ellen Prestly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Records: SPRING GROVE STATE HOSH TAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary and generalized arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from Dec. 13, 1959 , to Dec. 15, 1959 , that I lost saw the deceased alive on Dec. 15, 1959 , and that death occurred at 7:00p M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state)
SPRING GROVE STATE HOSPITAL | | | | DATE SIGNED
12-16-59 | | | |
| ACTUAL SIGNATURE
Stella Wachsler | | | | M.D. SPRING GROVE STATE HOSPITAL | | | |
| PHYSICIAN'S NAME (Type)
Stella Wachsler, M. D. | | | | Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-18-59 | 22c. NAME OF CEMETERY OR CREMATORY
Ebenezer | 22d. LOCATION (City, town, or county) | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Mr. C. Malling | | | ADDRESS
Lernantown, Md. | | 24a. REC'D BY REGISTRAR
DATE
DEC 18 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10107

CERTIFICATE OF DEATH

1942

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
<i>JOHN J. SMITH</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>Jan 15 1942</i> | | 5. TIME OF DEATH
<i>10:30 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Myocardial Infarction</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 10. DATE OF BIRTH
<i>Jan 15 1897</i> | | 11. TIME OF BIRTH
<i>10:30 AM</i> | | 12. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 13. NAME OF PHYSICIAN
<i>Dr. J. H. Smith</i> | | 14. NAME OF HOSPITAL
<i>St. Mary's Hospital</i> | | 15. NAME OF NURSE
<i>Miss J. H. Smith</i> | |
| 16. NAME OF FUNERAL HOME
<i>John J. Smith & Co.</i> | | 17. NAME OF MINISTER
<i>Rev. J. H. Smith</i> | | 18. NAME OF CHURCH
<i>St. Mary's Church</i> | |
| 19. NAME OF BURIAL PLACE
<i>St. Mary's Cemetery</i> | | 20. NAME OF INTERMENT
<i>Interment</i> | | 21. NAME OF CEMETERY
<i>St. Mary's Cemetery</i> | |
| 22. NAME OF CORPSE
<i>John J. Smith</i> | | 23. NAME OF CLOTHES
<i>White</i> | | 24. NAME OF SHIRT
<i>White</i> | |
| 25. NAME OF TIE
<i>White</i> | | 26. NAME OF PANTS
<i>White</i> | | 27. NAME OF SHOES
<i>White</i> | |
| 28. NAME OF HAT
<i>White</i> | | 29. NAME OF GLOVES
<i>White</i> | | 30. NAME OF SOCKS
<i>White</i> | |
| 31. NAME OF UNDERWEAR
<i>White</i> | | 32. NAME OF LINGERIE
<i>White</i> | | 33. NAME OF JEWELRY
<i>White</i> | |
| 34. NAME OF ACCESSORIES
<i>White</i> | | 35. NAME OF OTHERS
<i>White</i> | | 36. NAME OF OTHERS
<i>White</i> | |
| 37. NAME OF OTHERS
<i>White</i> | | 38. NAME OF OTHERS
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| 100. NAME OF OTHERS
<i>White</i> | | 101. NAME OF OTHERS
<i>White</i> | | 102. NAME OF OTHERS
<i>White</i> | |

10107

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. DATE OF BIRTH
11. TIME OF BIRTH
12. PLACE OF BIRTH
13. NAME OF PHYSICIAN
14. NAME OF HOSPITAL
15. NAME OF NURSE
16. NAME OF FUNERAL HOME
17. NAME OF MINISTER
18. NAME OF CHURCH
19. NAME OF BURIAL PLACE
20. NAME OF INTERMENT
21. NAME OF CEMETERY
22. NAME OF CORPSE
23. NAME OF CLOTHES
24. NAME OF SHIRT
25. NAME OF TIE
26. NAME OF PANTS
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98. NAME OF OTHERS
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100. NAME OF OTHERS
101. NAME OF OTHERS
102. NAME OF OTHERS

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13460

CERTIFICATE OF DEATH

13438

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heberville, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heberville, Md.</u> | |
| c. LENGTH OF STAY IN Tb <u>7 yrs</u> | | d. STREET ADDRESS <u>3106 Cresson Ave</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3106 Cresson Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Pezzica</u> Last <u>Pezzica</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1959</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/26/1888</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months <u>71</u> | IF UNDER 24 HRS. Days <u>71</u> Hours <u>71</u> Min. <u>71</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Cutter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Marble</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Mrs Viola L. Martin</u> | | Address <u>3106 Ave Cresson</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>163X Cancer of lung</u>
DUE TO (b) <u>163X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>163X</u>
DUE TO (b) <u>163X</u>
DUE TO (c) <u>163X</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12-12, 1958</u> to <u>12-29, 1959</u> , that I last saw the deceased alive on <u>12-28, 1959</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>B. Stanley Cohen</u> M.D. | | ADDRESS (Street, city or town, state) <u>7306 Edgely Rd Balto</u> DATE SIGNED <u>12/29/59</u> | |
| PHYSICIAN'S NAME (Type) <u>B. STANLEY COHEN, MD</u> | | 12/29/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1/2/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gowanson</u> ADDRESS <u>101 Hollins St.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

CERTIFICATE OF DEATH

1941

CHIEF OF BUREAU

CERTIFICATE OF DEATH

Reg. Dist. No. 13439

13461

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>8004 Old Harford Rd</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Calvin</u> Middle <u>N.</u> Last <u>Pierce Sr.</u> | | | 4. DATE OF DEATH
Month <u>Dec</u> Day <u>23</u> Year <u>1959</u> | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5-19-1917</u> | 9. AGE (In years last birthday)
<u>42</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>steel worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Herbert Pierce</u> | | | 14. MOTHER'S M maiden NAME
<u>Edith Kirby</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY NO.
<u>213-05-8812</u> | | 17. INFORMANT
<u>Alberta F. Pierce</u> Address <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the brain</u>
1930 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 1956, to <u>Dec. 23</u> , 1959, that I last saw the deceased alive on <u>Dec. 23</u> , 1959, and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
<u>Harold A. Grott</u> | | ADDRESS (Street, city or town, state)
<u>8100 Harford Rd.</u> DATE SIGNED
<u>12/22/59</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>H. A. GOTT, M.D.</u> | | <u>Balto 14, MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 22b. DATE THEREOF
<u>12-28-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Moreland Mem. Park</u> | |
| 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 29 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 1

25th Nov 1994

WILLIAM F. SWANSON 5132-70-819

13462

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Providence</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Providence</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>938 Ellendale Drive</u> | | | | e. STREET ADDRESS
<u>938 Ellendale drive</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ray W.</u> Middle <u>Pitts</u> Last | | | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>20</u> Year <u>1959</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-24-1879</u> | 9. AGE (In years last birthday)
<u>80</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>City emp.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>water dept.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Charles L. Pitts</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elmira Burnett</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<input type="checkbox"/> | | 16. SOCIAL SECURITY NO.
<input type="checkbox"/> | | INFORMANT
<u>Ethel Niemeyer</u> | | Address
<u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CEREBROVASCULAR DISEASE</u>
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.
(b) DUE TO
(c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month. <u> </u> Day. <u> </u> Year <u>19</u>
Hour a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1957</u> to <u>Dec 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC 13</u> , 19 <u>59</u> , and that death occurred at <u>1250 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>William A. Pillsbury</u> | | M.D.
<u>William A. Pillsbury</u> | | ADDRESS (Street, city or town, state)
<u>Timonium, Md.</u> | | DATE SIGNED
<u>12/22/59</u> | |
| PHYSICIAN'S NAME (Type)
<u>WILLIAM A. PILLSBURY</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 22b. DATE THEREOF
<u>12-23-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Jessup Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | | | ADDRESS
<u>5305 Harford Rd</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 23 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kruger</u> | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

125

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13463

CERTIFICATE OF DEATH

13441

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
3yr10mth13dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Clara Middle A. Last Pledge | | 4. DATE OF DEATH
Month December Day 20 Year 19 59 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 17, 1893 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. 66 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | 12. KIND OF BUSINESS OR INDUSTRY
U.S.F. & H. | |
| 13. BIRTHPLACE (State or foreign country)
Maryland | | 14. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. FATHER'S NAME
James L Amos | | 16. MOTHER'S MAIDEN NAME
Annie Gates | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
unknown | | 18. SOCIAL SECURITY NO.
217-01-2701 | |
| 19. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia with pleural empyema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic and acute alcoholism
INTERVAL BETWEEN ONSET AND DEATH
5-6 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 18, 19 59 to Dec. 20, 19 59 , that I last saw the deceased alive on Dec. 20, 19 59 , and that death occurred at 4:15 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Stella Wachsler | | DATE SIGNED
12-21-59 | |
| PHYSICIAN'S NAME (Type)
Stella Wachsler, M. D. | | ADDRESS (Street, city or town, state)
SPRING GROVE STATE HOSPITAL | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 24, 19 59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Louison Park | | 22d. LOCATION (City, town, or county) (State)
Balto Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John A. Temple 5311 Edmondson Ave | | 24a. REC'D BY REGISTRAR
DEC 23 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

42.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G253 12-14-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13442

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MD.
b. COUNTY Howard ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
VILLA NOVA | | c. LENGTH OF STAY IN 1b
1 1/2 YRS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
AUGSBURG HOME | | d. STREET ADDRESS
ROGERS AVE. | |
| 3. NAME OF DECEASED (Type or print)
First FRANCES Middle PLEINES Last | | 4. DATE OF DEATH
Month DEC. Day 9, Year 59 19 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APR. 10, 1869 |
| 9. AGE (In years last birthday)
90 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 11. BIRTHPLACE (State or foreign country)
SHREWSBURY PA. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
CHARLES | | 14. MOTHER'S MAIDEN NAME
ROSA BECK | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
----- | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
RECORDS AUGSBURG HOME | | Address 6811 CAMPFIELD Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Psychosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized Arterio-sclerosis | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs
6 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 23 , 19 58 , to Dec. 9 , 19 59 , that I last saw the deceased alive on Dec. 4 , 19 59 , and that death occurred at 10 A. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Paul L. Chamber | | DATE SIGNED
4/08 Liberty Hts 2 12/9/59 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/12/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Paul A. Heemann | | ADDRESS
6067 Harford Rd. | |
| 24a. REC'D BY REGISTRAR
DATE DEC 14 '59 | | 24b. REGISTRAR'S SIGNATURE
Charles S. Hume | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

13465

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Georgia b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson 4 | | c. LENGTH OF STAY IN 1b
4 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1817 Cromwood Road | | d. STREET ADDRESS
49X-3 | |
| 3. NAME OF DECEASED (Type or print)
First CHARLOTTE Middle BARBER Last POWERS | | 4. DATE OF DEATH
Month December Day 29, Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 15, 1887 |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months 72 Days 72 Hours 72 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Georgia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frank Barber | | 14. MOTHER'S MAIDEN NAME
Helen Circopley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
None | |
| INFORMANT
Family Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) CORONARY OCCLUSION
DUE TO
(c) CORONARY HEART DISEASE | | | |
| INTERVAL BETWEEN ONSET AND DEATH
MINUTES
MINUTES
YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/2/59 , 19 59 , to 12/29/59 , that I last saw the deceased alive on 12/2 , 19 59 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 25 W. Pa. Ave DATE SIGNED 12/30/59
ACTUAL SIGNATURE Donald L. Somerville M.D.
PHYSICIAN'S NAME (Type) Donald L. Somerville, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
Dec. 30, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Henderson Funeral Home | | 22d. LOCATION (City, town, or county) (State)
Savannah, Georgia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John Burns' Sons, Towson, Maryland | | 24a. REC'D BY REGISTRAR
DATE JAN 4 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Carling S. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10183

CHARLOTTE GARDEN POWER

1124

Georgia

Johnston

A. M. Johnston

Colon A

Johnston Road

CHARLOTTE GARDEN POWER

December 20,

October 12, 1927

x

W. H. H. H.

W. H. H. H.

Georgia

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

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Johnston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13466

CERTIFICATE OF DEATH

Reg. Dist. No.

13444

| | | | |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 22, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
53 Baltimore 22, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1625 Searles Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Frank Middle PURAL Last | | 4. DATE OF DEATH
Month 12 Day 21 Year 19 59 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-4-1894 |
| 9. AGE (In years last birthday)
65 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Longshoreman | 11. BIRTHPLACE (State or foreign country)
Baltimore Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A | | 13. FATHER'S NAME
Joseph Pural | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WW I | |
| 16. SOCIAL SECURITY NO.
214-01-0763A | | 17. INFORMANT
Joseph Pural 8330 Bletzer Rd. (22) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Left Lung.
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma to Liver.
DUE TO (c) Hypertensive C.V.D. Arteriosclerosis & Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. p. 19 Month, Day, Year | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from her , 19 59 , to Dec 21 , 19 59 , that I last saw the deceased alive on 12/21/59 , 19 59 , and that death occurred at 12:10 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Melvin J. Jaworski | | DATE SIGNED
12/21/59 | |
| PHYSICIAN'S NAME (Type)
MELVIN J. JAWORSKI M.D. | | ADDRESS (Street, city or town, state)
2711 Eastern Ave | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-24-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | | 22d. LOCATION (City, town, or county) (State)
7401 German Hill Rd Ba. Co | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Weber & Sons Inc | | 24a. REC'D BY REGISTRAR
DEC 22 '59 | |
| ADDRESS
401 S. Chester St | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Krome | |

882 E. L.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13467

CERTIFICATE OF DEATH

Reg. Dist. No.

13445

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
Towson Convalescent Home
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
301 W. Chesapeake Ave | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Md.
b. COUNTY
Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
4225 Loch Raven Blvd.
d. STREET ADDRESS
4225 Loch Raven Blvd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
William Reinhardt | | 4. DATE OF DEATH
Month Dec. Day 23 Year 19 59 | |
| 5. SEX
M. | 6. COLOR OR RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Apr. 20, 1871 |
| 9. AGE (In years last birthday)
88 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired, Owens Ill. Glass Co. | | 10b. KIND OF BUSINESS OR INDUSTRY
Glass Co. | |
| 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Reinhardt | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
INFORMANT
Address Blvd
Miss Katherine Reinhardt, 4225 Loch Raven | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior descending C.V. Dis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia
INTERVAL BETWEEN ONSET AND DEATH
48 hrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. — 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 19 52 , to Dec 23 , 19 59 , that I last saw the deceased alive on Dec 22 , 19 59 , and that death occurred at 2:55 M, from the causes and on the date stated above.
ACTUAL SIGNATURE Lester A. Wall Jr M.D. 1039 St Paul St DATE SIGNED 12/24/59
PHYSICIAN'S NAME (Type) LESTER A. WALL JR | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/26/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
London Park Cemetery | | 22d. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Witzke Funeral Dir. 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR
DATE DEC 28 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

1943

CERTIFICATE OF DEATH

1943

1. Name of deceased: William Reinhardt
2. Date of death: Dec. 15, 1943
3. Place of death: Germany
4. Age at death: 35
5. Sex: Male
6. Race: White
7. Cause of death: Unknown
8. Signature of physician: W. Reinhardt
9. Signature of registrar: W. Reinhardt
10. Signature of informant: W. Reinhardt

11. Name of informant: W. Reinhardt
12. Address of informant: Germany
13. Date of birth: Dec. 15, 1943
14. Place of birth: Germany
15. Age at birth: 35
16. Sex at birth: Male
17. Race at birth: White
18. Cause of birth: Unknown
19. Signature of physician: W. Reinhardt
20. Signature of registrar: W. Reinhardt
21. Signature of informant: W. Reinhardt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13468

CERTIFICATE OF DEATH

Reg. Dist. No.

13446

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural</u> <u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X</u> <u>Rural</u> <u>Towson</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Glenarm Road</u> | | d. STREET ADDRESS
<u>Glenarm Road</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Sister Mary Leontine Reinisch</u> | | 4. DATE OF DEATH
Month Day Year
<u>December</u> <u>8</u> <u>1959</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 13, 1869</u> |
| 9. AGE (In years last birthday)
<u>90</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RELIGIOUS</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>New York City</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Edward Reinisch</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Loeffler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u></u> | |
| 17. INFORMANT
<u>Sister M. Peter Fourier</u> | | Address
<u>Notch Cliff, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>
<u>442X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-renal vascular disease</u>
DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August</u> , 19 <u>52</u> , to <u>December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 1</u> , 19 <u>59</u> , and that death occurred at <u>7:45 P.</u> -M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>7501 York Road Towson 4, Md.</u> DATE SIGNED <u>12/8/59</u> | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell M.D.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>12-10-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>VILLA MARIA CEM.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>NOTCH CLIFF NE TOWSON, MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles S. Giler</u> | | ADDRESS
<u>9015 CONKLIN ST. BALTO, 24, MD.</u> | |
| 24a. REC'D BY REGISTRAR
<u>11 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | |

3251

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13469

CERTIFICATE OF DEATH

Reg. Dist. No.

13447

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE | | c. LENGTH OF STAY IN 1b JULY 19, 1959 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8344 LIBERTY RD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RUTH Middle VERONA Last RENNER | | 4. DATE OF DEATH Month 12 Day 4 Year 19 59 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/30/02 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL | | 10b. KIND OF BUSINESS OR INDUSTRY Department Store | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM C. HIDEY | | 14. MOTHER'S MAIDEN NAME CARRIE GLADMON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) XXX | | 16. SOCIAL SECURITY NO. Yes | |
| 17. INFORMANT MRS. HOFFMAN | | Address 8344 LIBERTY RD, BALTO. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF OVARY & METASTASES
175.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 12, 1959 , to Dec. 4, 1959 , that I last saw the deceased alive on Dec. 4, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edwin Z. Pierpont | | ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO. 7, MD. | |
| PHYSICIAN'S NAME (Type) EDWIN Z. PIERPONT, M.D. | | DATE SIGNED 12/4/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/7/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Western Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickney | | ADDRESS Balto - 17, Md. | |
| 24a. REC'D BY REGISTRAR DEC 8 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

CERTIFICATE OF DEATH

12565

| | | | | | | | | | | | | | | | |
|----------------------|--|---------------|--|--------------------|--|---------------------|--|--------------------|--|---------------------|--|-----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | M | | 45 | | JAN 15 1880 | | BALTIMORE | | MD | | MD | | USA | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | SINGLE | | MARRIED | | WIDOWED | | DIVORCED | | OTHER | |
| Physician | | High School | | Married | | Never | | Never | | Never | | Never | | Never | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| JAN 15 1925 | | 10:30 AM | | BALTIMORE | | MD | | MD | | USA | | HEART DISEASE | | NATURAL | |
| CERTIFICATE OF DEATH | | FURNISHED BY | | DATE OF FURNISHING | | PLACE OF FURNISHING | | CITY OF FURNISHING | | STATE OF FURNISHING | | COUNTRY OF FURNISHING | | MANNER OF FURNISHING | |
| JAMES H. HARRIS | | JAN 15 1925 | | BALTIMORE | | MD | | MD | | USA | | HEART DISEASE | | NATURAL | |

1. This certificate is to be filled out by the physician or other person who has attended the deceased during his last illness, or by the coroner if the death was sudden and unexpected, or by the medical examiner if the death was due to violence or other external cause.

2. The cause of death should be stated in as many words as possible, and should include the immediate cause, the remote cause, and the underlying cause.

3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.

4. The date of death should be stated in full, including the day, month, and year.

5. The time of death should be stated in full, including the hour, minute, and second.

6. The place of death should be stated in full, including the city, county, and state.

7. The city of birth, state of birth, and country of birth should be stated in full.

8. The occupation, education, marriage, and other personal history of the deceased should be stated in full.

9. The certificate should be signed by the physician or other person who has attended the deceased, or by the coroner or medical examiner if the death was sudden and unexpected.

10. The certificate should be filed with the local health department, and a copy should be sent to the State Department of Health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13470

CERTIFICATE OF DEATH

Reg. Dist. No.

13448

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville, 28 | | | | c. LENGTH OF STAY IN 1b
52 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
621 Rest Ave | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle William Last Rest | | | | 4. DATE OF DEATH
Month Dec Day 25 Year 19 59 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/26/1888 | |
| 9. AGE (In years last birthday)
71 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
foreman | | 10b. KIND OF BUSINESS OR INDUSTRY
Gas & Electric | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 13. FATHER'S NAME
John W. Rest | | | | 14. MOTHER'S MAIDEN NAME
Family records 621 Rest Ave | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | | | 17. INFORMANT
Family records Address 621 Rest Ave | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
25 min. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour _____ a. m. _____ p. m. _____
Month _____ Day _____ Year 19 59 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from 12-15 , 19 59 , to 12-25 , 19 59 , that I last saw the deceased alive on 12-22 , 19 59 , and that death occurred at 10:04 A. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 46 Church Road DATE SIGNED 12-26-59 | | | | | | | |
| ACTUAL SIGNATURE Thomas F. Herbert M.D. | | | | PHYSICIAN'S NAME (Type) Thomas F. Herbert M.D. Ellicott City, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/28/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Torrance Park | | 22d. LOCATION (City, town, or county) (State)
Balto. Co. Ind | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arthur L. Kraus 28 | | | | 24a. REC'D BY REGISTRAR
DATE DEC 29 59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

1 ~~X~~

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13449

13471

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodensburg</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<input checked="" type="checkbox"/> <u>Woodensburg</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Rebecca</u> Middle <u>W.</u> Last <u>Rhoten</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>19</u> Year <u>1959</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 19, 1923</u> |
| 9. AGE (In years last birthday)
<u>36</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore County</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Ernest E. Wooden</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Lois Benson</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | |
| 16. SOCIAL SECURITY NO.
<u>215-24-2513</u> | | INFORMANT Address
<u>Virgil T. Rhoten, Woodensburg, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Amelanotic melanoma</u>
<u>190.9</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u> </u> DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>29 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 12</u> , 19 <u>57</u> , to <u>Dec 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>59</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D. | | ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>Dec 20, 1959</u> | |
| PHYSICIAN'S NAME (Type) <u>Clarence E. McWilliams</u> | | <u>Reisterstown, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>12-22-59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Woodensburg Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Woodensburg, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>William Cook, Inc., 1217 St. Paul Street</u> | | ADDRESS
<u> </u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>DEC 22 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Huns</u> | |

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G254 1-4-60 et

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CERTIFICATE OF DEATH

Reg. Dist. No.

13450

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|--|----------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TOWSON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TOWSON 55</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>20 East Burke Ave.</u> | | | | d. STREET ADDRESS
<u>20 East Burke Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Mary E. Rick</u> | | | | 4. DATE OF DEATH Month Day Year
<u>December 20 1959</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Dec. 16, 1898</u> | | 9. AGE (In years last birthday) yrs. <u>61</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MANAGER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>CONDALYNN INC</u> | | 11. BIRTHPLACE (State or foreign country)
<u>SPARROWS PT. MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Mc MANN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>NONA McCleary</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>219-28-4759</u> | | 17. INFORMANT
<u>George C. Rick</u> | | Address
<u>20 E. BURKE AVE. #4</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of ovary (right)</u>
<u>1750</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 1/2 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>54</u> , to <u>12/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/20</u> , 19 <u>59</u> , and that death occurred at <u>1145 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Edward Gordon Grau</u> | | | | ADDRESS (Street, city or town, state)
<u>8523 Loch Raven Blvd</u> | | DATE SIGNED
<u>12/21/59</u> | |
| PHYSICIAN'S NAME (Type)
<u>Edward Gordon Grau</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-23-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>BALTIMORE</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John C. Mullen Inc. - 2431 E. Oliver St.</u> | | | | 24a. REC'D BY REGISTRAR
<u>DEC 24 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur E. Thomas</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|---|--|--|--|--|--|--|--------------------------------|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> | | | | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Ellicott City</u> | | | | | c. LENGTH OF STAY IN lb
<u>Okonton</u> <u>83X-3</u> | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Oella Ave.</u> | | | | | d. STREET ADDRESS
<u>Okonton</u> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
<u>ROScoe</u> <u>RIGGLEMAN</u> | | | | | 4. DATE OF DEATH
Month <u>December</u> Day <u>9</u> Year <u>1959</u> | | | | | | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>ABOUT XXXX 1919</u> <u>40?</u> yrs. | | 9. AGE (In years last birthday) IF UNDER 1 YEAR
Months <u>40?</u> Days <u>40?</u> Hours <u>40?</u> Min. <u>40?</u> | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Gen. Construction</u> | | | | | 11. BIRTHPLACE (State or foreign country)
<u>Hardy County W. Va.</u> | | | | | | | | | |
| 13. FATHER'S NAME
<u>Robert Riggleman</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Smith</u> | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W. #2</u> | | | | | | | | | |
| 16. SOCIAL SECURITY NO.
<u>unknown</u> | | | | | 17. INFORMANT
<u>Mr. Dayton Cook, Hearndon, Rt. #2</u> <u>Va.</u> | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Avulsion of brain</u>
<u>976X</u> DUE TO <u>gunshot wound of head</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u> DUE TO <u>gunshot wound of head</u>
(c) <u>gunshot wound of head</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Shot self in head</u> | | | | | 20c. TIME OF INJURY
Month, Day, Year
<u>4:30</u> <u>p.m.</u> <u>12/9</u> <u>1959</u> | | | | | | | | | |
| 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Road</u> | | | | | 20f. (City or town) (County) (State)
<u>Ellicott City</u> <u>Balto.</u> <u>Md</u> | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED
<u>12/10/59</u> | | | | |
| ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u> | | | | | Address (Street, city, town, or county)
<u>4611 Park Heights A.</u> | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Kneal</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | 22b. DATE THEREOF
<u>12/14/59</u> | | | | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Newhouse Cemetery</u> | | | | | | | | | |
| 22d. LOCATION (City, town, or country) (State)
<u>Rig, West Virginia</u> | | | | | 24a. REC'D BY REGISTRAR
<u>DEC 14 '59</u> | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Kneal</u> | | | | | | | | | |
| 23. FUNERAL DIRECTOR
<u>W. Vernon Lemon</u> | | | | | ADDRESS
<u>4611 Park Heights A.</u> | | | | | 24a. REC'D BY REGISTRAR
<u>DEC 14 '59</u> | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Kneal</u> | | | | | 24c. REGISTRAR'S SIGNATURE
<u>Charles E. Kneal</u> | | | | | 24d. REGISTRAR'S SIGNATURE
<u>Charles E. Kneal</u> | | | | | | | | | |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella
c. LENGTH OF STAY IN lb Oella
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Oella Ave | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella
d. STREET ADDRESS 102 Oella Ave
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MINNIE RILEY
First Middle Last | | | | 4. DATE OF DEATH Dec. 21, 1959
Month Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-19-1889 | |
| 9. AGE (In years last birthday) 70 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles Back | | | | 14. MOTHER'S MAIDEN NAME Mary Back | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Walter Green, Catonsville, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 903.0 ACUTE PULMONARY EDEMA
DUE TO (b) FRACTURED LEFT HIP
DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH 30 MIN.
1 HOUR
NOT KNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES, OBESITY | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SLIPPED ON FLOOR AT HOME, AND FELL | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 2:00 p.m. 12-21 1959 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME | | 20f. (City or town) (County) (State) OELLA, BALTO., MD. | |
| 21. I certify that I attended the deceased from 12-21 , 19 59 , to 12-21 , 19 59 that I last saw the deceased alive on 12-21 , 19 59 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Peter V. Thorpe | | ADDRESS (Street, city or town, state) COLUMBIA ROAD DATE SIGNED 12-22-59 | | | | | |
| PHYSICIAN'S NAME (Type) PETER V. THORPE, MD | | ELLICOTT CITY, MD. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-24-59 | | 22c. NAME OF CEMETERY OR CREMATORY Good Shepherd | | 22d. LOCATION (City, town, or county) (State) Ellicott City, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md | | | | 24a. REC'D BY REGISTRAR DATE DEC 28 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
28 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle K. Last RINGLE | | 4. DATE OF DEATH
Month December Day 12 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 16, 1895 |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (State or foreign country)
Granville, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Harry Ringle | | 14. MOTHER'S MAIDEN NAME
Anna Switzer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW I 705-05-0892 | |
| 17. INFORMANT
Clin. Records VAH Balto, Md., Ft. Howard Div. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONITIS
492x THROMBOSIS OF BRANCH OF RIGHT MIDDLE CEREBRAL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ARTERY WITH LEFT HEMIPLEGIA
(c) CEREBRAL ARTERIOSCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH
1 MONTH
1 MONTH
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 11, 19 59 , to December 12, 19 59 , and that death occurred at 1:05 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Dr. J.R. Hood | | ADDRESS (Street, city or town, state)
VAH, BALTO. MD. FORT HOWARD DIVISION | |
| PHYSICIAN'S NAME (Type)
T.R. HOOD, M.D. | | DATE SIGNED
12/13/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-16-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Peter's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm Cook-Blight, Inc. 6009 Harford Rd. | | 24a. REC'D BY REGISTRAR
DEC 16 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneiss | | | |

WM. COOK-BLIGHT, INC. 6009 HARFORD RD., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13454

13476

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>6 Months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>House in the Pines</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>GEORGE NELSON ROGERS</u> | | 4. DATE OF DEATH
Month Day Year
<u>December 2, 1959</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 22, 1877</u> |
| 9. AGE (In years last birthday)
<u>82</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Advertising</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Radio</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>William F. Rogers, Sr.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Emma Holloway</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs. Marion D. Rogers</u> | | Address
<u>1518 Bolton Street</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia - Cardiac in self</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Coronary Thrombosis - Art. sclerosis</u>
DUE TO (c) <u>Senility</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>1 week</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 17, 1959</u> , to <u>Dec. 2, 1959</u> , that I last saw the deceased alive on <u>Dec. 2, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Bernard J. Cohen</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Bernard J. Cohen</u> | | <u>Marylander Apts.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | 22b. DATE THEREOF
<u>Dec. 4, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Green Mount</u> | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John O. Mitchell & Sons, Inc. 1900 Eutaw Place</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 4 '59</u>
DATE | |
| | | 24b. REGISTRAR'S SIGNATURE
<u>Christina L. Hanna</u> | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|-------------------------|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY ✓ | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Parkville | | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 3 Vol-4 | | | d. STREET ADDRESS
902 N. Central Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Ashford and Harwood | | | | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
WARREN | | First | | Middle | | Last
ROLLINS | | 4. DATE OF DEATH
Month December Day 17, Year 19 59 | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
2/14/1902 | | 9. AGE (In years last birthday) 57 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Pitt Co., N.C. | | 12. CITIZEN OF WHAT COUNTRY? | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 13. FATHER'S NAME
Levy Rollins | | | | | 14. MOTHER'S MAIDEN NAME
Liddie Moore | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
230014248 | | 17. INFORMANT
Lillie Adams | | Address
1304 Colonial Greenville, N.C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }
(b) Coronary insufficiency
DUE TO
(c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
William V. Lovitt, Jr. | | EXAMINER'S NAME (Type)
William V. Lovitt, Jr., M.D. | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
12/18/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
12/19/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Brown Hill | | 22d. LOCATION (City, town, or country) (State)
Greenville N.C. | | | |
| 23. FUNERAL DIRECTOR
Arlington S. Phillips | | ADDRESS
1808 N. Montgomery | | 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Knap | | | |



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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

13478

13456

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore County | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | c. LENGTH OF STAY IN 1b
X Parkville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
2913 Edgewood Avenue | | d. STREET ADDRESS
2913 Edgewood Avenue | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Jane Last Romans | | 4. DATE OF DEATH
Month December Day 6th. Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec 16th., 1886 |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months 11 Days 20 | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John G. Schaffer | | 14. MOTHER'S MAIDEN NAME
Anna Davidson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Bernard Farace-2913 Edgewood Avenue | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Cerebro-Vascular Thromboses
332 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized
DUE TO (c) Age + diabetic history. | | INTERVAL BETWEEN ONSET AND DEATH
2 wks
3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Moderately severe Internal Hemorrhoidal Bleeding | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month Aug Day 5 Year 1959
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug , 19 55 to Dec , 19 59 , that I last saw the deceased alive on Dec 5 , 19 59 , and that death occurred at 8:00 A. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 9005 HARFORD Rd. DATE SIGNED 12/8/59 | | | |
| ACTUAL SIGNATURE Frank T. Kasik Jr. M.D. | | | |
| PHYSICIAN'S NAME (Type) FRANK T. KASIK JR. BALTO 14 Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-9-1959 | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | 22d. LOCATION (City, town, or county) (State)
Belair Rd. Balto: Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George J. Ruth, Inc.-1735 Harford Avenue, Balto: Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 11 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna |

CERTIFICATE OF DEATH

Reg. Dist. No.

13457

13479

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Howard | | c. LENGTH OF STAY IN 1b
169 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle L. Last ROOT | | 4. DATE OF DEATH
Month DECEMBER Day 19 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 23, 1915 |
| 9. AGE (In years last birthday) 44 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pilot- | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. AIR FORCE | |
| 11. BIRTHPLACE (State or foreign country)
Burlington, Vermont | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Root | | 14. MOTHER'S MAIDEN NAME
Eulia Barttro | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
PL 28 095-10-2711 | |
| 17. INFORMANT
Clin. Records, Vet. Adm. Hosp. Balto. Md. Ft. Howard Div | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO
(c) UNKNOWN | | INTERVAL BETWEEN ONSET AND DEATH
10 MINUTES | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CEREBRAL THROMBOSIS WITH ENCEPHALOMALACIA OF RT TEMP LOBE; OLD POST. & APICAL MYO. INFARCTS; HEMORRHAGES SM. & LG. BOWEL; PASS. CONGEST. LIVER; ASCVD. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 3, 1959 , to December 19, 1959 , and that death occurred at 10:50 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Joseph J. Cillo | | ADDRESS (Street, city or town, state)
VAH, BALTIMORE, MD. - FT HOWARD DIV 12/19/59 | |
| PHYSICIAN'S NAME (Type)
Joseph J. Cillo, | | M.D. VAH, Balto., Md.-Ft. Howard Div. 12-19-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
12-21-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | 22d. LOCATION (City, town, or county) (State)
Richmond, Vt. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc., Baltimore, Md. | | 24a. REC'D BY REGISTRAR
DEC 23 '59 | |
| ADDRESS
6009 Harford Road | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4 of 4

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

13043

1

1

STATE OF

NEW YORK

DECEASED

ATTEST: COUNTY CLERK

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said office, at the City of New York, this 1st day of January, 1901.

JOHN J. VAN BUREN, Mayor of the City of New York.

JOHN J. VAN BUREN, Mayor of the City of New York.

JOHN J. VAN BUREN, Mayor of the City of New York.

JOHN J. VAN BUREN, Mayor of the City of New York.

JOHN J. VAN BUREN, Mayor of the City of New York.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13458

Reg. Dist. No.

FOR STATE HEALTH DEPT.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Middle River (Zone 20)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>54 Middle River (Zone 20)</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>3 B Westway North</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Robert Luther Rose</u> | | 4. DATE OF DEATH
Month Day Year
<u>December 1 1959</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 26, 1932</u> |
| 9. AGE (In years last birthday)
<u>27 yrs.</u> | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Tech. Eng.</u> | | 12. KIND OF BUSINESS OR INDUSTRY
<u>Martin Company</u> | |
| 13. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 14. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. FATHER'S NAME
<u>Virgil A. Rose</u> | | 16. MOTHER'S MAIDEN NAME
<u>Marie Davenport</u> | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 18. SOCIAL SECURITY NO.
<u>227-42-4622</u> | |
| 19. INFORMANT
<u>Geneva Rose</u> | | Address
<u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GUN SHOT WOUND - 25 CAL. PISTOL -</u>
<u>976X</u>
DUE TO (b) <u>RIGHT Temple - (PARITAL)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Shot self in Rt. Temple</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>12-1-59</u>
<u>10 a.m.</u> 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | 20f. (City or town) (County) (State)
<u>Middle River - Balt. Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>M.B. Davis</u> | | DATE SIGNED
<u>12/1/59</u> | |
| EXAMINER'S NAME (Type)
<u>M.B. DAVIS M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>12-3-1959</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Waller & Waller Funeral Home</u> | 22d. LOCATION (City, town, or county) (State)
<u>Greenbelt Co. W. Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James J. Buzinski</u> | | 24. RECEIVED BY REGISTRAR
DATE
<u>DEC 3 '59</u> | |
| ADDRESS
<u>1407 Eastern Ave.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG253 12-24-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13459

13333

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
53 Dundalk | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
11 Patapsco Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First IRENE Middle MARY Last ROSEL | | 4. DATE OF DEATH
Month December Day 2 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 12, 1902 |
| 9. AGE (In years last birthday)
56 1/4 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph F. Trabert | | 14. MOTHER'S MAIDEN NAME
Barbara Schreifer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Peter M. Rosel | | Address
11 Patapsco Ave. —22 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardi-Vascular Disease - 4 yrs
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
5 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug. 1955 , 19 to Dec , 1959, that I last saw the deceased alive on Nov. 20 , 1959, and that death occurred at 8:15 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
M B Davis | | ADDRESS (Street, city or town, state) DATE SIGNED
6800 MORNINGSTAR MD - 12/2/59 | |
| PHYSICIAN'S NAME (Type)
M. B. DAVIS | | DUNDALK - 22 MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/5/59 | 22c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | 22d. LOCATION (City, town, or county) (State)
Dundalk, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home | | ADDRESS
2112 Dundalk Ave., 22. | |
| 24a. REC'D BY REGISTRAR
DATE DEC 7 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13460

13481

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | d. STREET ADDRESS
4116 Glenhunt Road | |
| 3. NAME OF DECEASED (Type or print)
First VICTOR Middle (NMI) Last RYBACKI | | 4. DATE OF DEATH
Month DECEMBER Day 10 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/21/91 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months 68 Days 68 Hours 68 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cement Finisher | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter Rybacki | | 14. MOTHER'S MAIDEN NAME
Sophia (unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
218-09-8222 | |
| 17. INFORMANT
Clin. Records, Vets. Adm. Hosp. Balto, Md. Ft. Howard Div. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONITIS
DUE TO
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CVA
DUE TO
(c) ARTERIOSCLEROTIC HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
1 MONTH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 16, 19 59 to December 10, 19 59 , and that death occurred at 2:45 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) BALTIMORE, MD. FORT HOWARD DIVISION DATE SIGNED 12/10/59 | | | |
| ACTUAL SIGNATURE Lawrence J. Mazzei, M.D. | | PHYSICIAN'S NAME (Type) LAWRENCE J. MAZZEI, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/14/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Michael Sadowski | | 24a. REC'D BY REGISTRAR
DEC 14 '59 | |
| ADDRESS
1808 Eastern Avenue
Baltimore, Maryland | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1898

Witnessed by: *James M. H. H.*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G254 1-8-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13461

13482

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> | | | | c. LENGTH OF STAY IN 1b <u>101 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>M.</u> Last <u>SAKOWSKI</u> | | | | 4. DATE OF DEATH <u>Dec.</u> Month <u>20</u> , Day <u>19</u> Year <u>59</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 19, 1909</u> | |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stitcher Operator</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Sakowski</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Wisniewski</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u> | | | | 16. SOCIAL SECURITY NO. <u>213-09-3655</u> | | | |
| 17. INFORMANT <u>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERNEPHROMA OF KIDNEY LEFT WITH EXTENSIVE METASTASES TO BOTH LUNGS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>180X</u> (c) <u>UNKNOWN</u>
DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180X</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>September 10 19 59</u> to <u>12/20/59</u> , 19 <u>59</u> , and that death occurred at <u>8:25A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>S. Arce</u> | | | | DATE SIGNED <u>12/20/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>S. ARCE, M. D.</u> | | | | ADDRESS (Street, city or town, state) <u>VAH, BALTO. MD. FT HOWARD DIV.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>12/23/59</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u> | | | | ADDRESS <u>2007 Eastern Ave. Balto. Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u>DEC 22 '59</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u> | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13482

11

13481

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13462

Reg. Dist. No.

13483

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TIMONIUM</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X TIMONIUM</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>2420 YORK ROAD</u> | | e. STREET ADDRESS
<u>2420 YORK ROAD</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>VERNON CHARLES SANDERS, SR.</u> | | 4. DATE OF DEATH
Month <u>DECEMBER</u> Day <u>4</u> Year <u>1959</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>FEB. 18, 1914</u> |
| 9. AGE (In years last birthday)
<u>45</u> yrs. | | IF UNDER 1 YEAR
Months <u>4</u> Days <u>12</u> | IF UNDER 24 HRS.
Hours <u>12</u> Min. <u>59</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SUPERINTENDENT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>SOUTHERN DINER CO.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>EDWIN SANDERS</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARGARET SCHMIDT</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>217-05-3245</u> | |
| 17. INFORMANT
<u>FAMILY RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Insufficiency</u>
(c) <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Charles F. O'Donnell</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>Charles F. O'Donnell</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>DEC. 7, 1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>ST. JOSEPH'S CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>TEXAS, BALTIMORE CO., MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John Burns' Sons, Towson, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 7 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | DATE SIGNED
<u>12/5/59</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: ☐ MALE ☐ FEMALE
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
8. CAUSE OF DEATH: _____
9. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE
10. SIGNATURE OF EXAMINER: _____
11. DATE: _____
12. PLACE: _____

COPIES OF THIS CERTIFICATE
SHALL BE FURNISHED TO THE
LOCAL HEALTH OFFICER
AND TO THE COUNTY CLERK
OF THE COUNTY IN WHICH
THE DECEASED RESIDES
AT THE TIME OF DEATH

THIS CERTIFICATE IS TO BE
FILED IN THE DEPARTMENT
OF HEALTH RECORDS
AND IN THE COUNTY CLERK'S
OFFICE
IN THE COUNTY IN WHICH
THE DECEASED RESIDES
AT THE TIME OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13463

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Mississippi</u> b. COUNTY <u>Walsh</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jayess</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2165 Lorraine Ave.</u> | | d. STREET ADDRESS <u>R.F.D.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Hazel Emma</u> Middle <u>Sartin</u> Last <u>Sartin</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1959</u> | |
| 5. SEX <u>Fem.</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mch. 10. 1898</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (State or foreign country) <u>MS</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u> </u> | | 13. FATHER'S NAME <u>Harry L. Spencer</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mellie Ball</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Rev. Fred Sartin Jayess</u> Address <u>Miss</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO <u>260x</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u>
DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>Dec. 6, 1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>12/7/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sartinsville, Mississippi</u> | | 22d. LOCATION (City, town, or county) (State) <u> </u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Man. J. Dickner & Son - Bartlett</u> ADDRESS <u> </u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>DEC 8 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF ATTENDING PHYSICIAN | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF WITNESSES | | 17. SIGNATURE OF FUNERAL HOME | | 18. SIGNATURE OF BURIAL PLACE | |
| 19. SIGNATURE OF VITAL RECORDS OFFICE | | 20. SIGNATURE OF HEALTH DEPARTMENT | | 21. SIGNATURE OF COUNTY CLERK | |
| 22. SIGNATURE OF STATE DEPARTMENT OF HEALTH | | 23. SIGNATURE OF STATE ARCHIVES | | 24. SIGNATURE OF STATE LIBRARY | |
| 25. SIGNATURE OF STATE MUSEUM | | 26. SIGNATURE OF STATE HISTORICAL SOCIETY | | 27. SIGNATURE OF STATE UNIVERSITY | |
| 28. SIGNATURE OF STATE COLLEGE | | 29. SIGNATURE OF STATE SENATE | | 30. SIGNATURE OF STATE ASSEMBLY | |
| 31. SIGNATURE OF STATE JUDICIAL BRANCH | | 32. SIGNATURE OF STATE EXECUTIVE BRANCH | | 33. SIGNATURE OF STATE LEGISLATIVE BRANCH | |
| 34. SIGNATURE OF STATE COURTS | | 35. SIGNATURE OF STATE BAR | | 36. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 37. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 38. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 39. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 40. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 41. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 42. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 43. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 44. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 45. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 46. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 47. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 48. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 49. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 50. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 51. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 52. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 53. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 54. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 55. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 56. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 57. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 58. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 59. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 60. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 61. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 62. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 63. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 64. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 65. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 66. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 67. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 68. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 69. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 70. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 71. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 72. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 73. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 74. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 75. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
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| 79. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 80. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 81. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 82. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 83. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 84. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 85. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 86. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 87. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 88. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 89. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 90. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 91. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 92. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 93. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 94. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 95. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 96. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 97. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 98. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 99. SIGNATURE OF STATE JUDICIAL OFFICIALS | |
| 100. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 101. SIGNATURE OF STATE JUDICIAL OFFICIALS | | 102. SIGNATURE OF STATE JUDICIAL OFFICIALS | |

CERTIFICATE OF DEATH

Reg. Dist. No.

13486

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pikesville</u> | | c. LENGTH OF STAY IN 1b
<u>x Pikesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>3501 Overbrook Rd.</u> | | d. STREET ADDRESS
<u>3501 Overbrook Rd.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Morris F.</u> Middle <u>Scherlis</u> Last <u></u> | | 4. DATE OF DEATH
Month <u>12</u> Day <u>28</u> Year <u>1959</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6/8/1918</u> |
| 9. AGE (years last birthday)
<u>41</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | 11. IF UNDER 24 HRS.
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Wholesale</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jacob Scherlis</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ethel</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u></u> | |
| INFORMANT
<u>Sarah D. Scherlis - Home</u> | | Address
<u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<u>169X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>12/18/59</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Aug 8</u> , 19 <u>57</u> to <u>12/10/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/18/59</u> , 19 <u>59</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>M. S. Shilling M.D.</u> | | DATE SIGNED
<u>2500 Eutan Place</u> | |
| PHYSICIAN'S NAME (Type)
<u>M. S. Shilling M.D.</u> | | <u>Baltimore, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>12/30/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Bethel Spring</u> | 22d. LOCATION (City, town, or county) (State)
<u>Harrellstown, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Sol. Levinson & Bros Inc</u> | | 24a. REC'D BY REGISTRAR
<u>1124-26</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | | DATE
<u>JAN 6 '60</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

825

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

CERTIFICATE OF DEATH

Reg. Dist. No.

13486

| | | | | | | | |
|---|--|-------------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home | | | | d. STREET ADDRESS 201 E. North Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH BODINE SCHMIDT | | | | 4. DATE OF DEATH December 28 1959 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 19, 1872 | |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME John William Bodine | | | | 14. MOTHER'S MAIDEN NAME Eugenia E. Watkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. None | | | |
| INFORMANT Mrs. Minnie Humphries-3124 Howard Pk. Ave. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
450.0 IMMEDIATE CAUSE (a) Generalized Arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Procidencia Rectum Recent.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 58 , 19, to 12/28/59 , that I last saw the deceased alive on 12/27/59 , 19, and that death occurred at 1000A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1303 Frederick Rd (28) DATE SIGNED 12/29/59
ACTUAL SIGNATURE Wm E McGrath M.D.
PHYSICIAN'S NAME (Type) William E. McGrath, M.D. 1303 Frederick Ave. - 28 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/30/1959 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hghts. Ave | | | | 24a. REC'D BY REGISTRAR DEC 30 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13161

CERTIFICATE OF DEATH

13485

Full name of deceased: ELIZABETH BOGINS SCHMIDT
Date of birth: 1901, 12, 18
Place of birth: Washington, D. C.
Cause of death: ...
Date of death: ...
Place of death: ...

Signature of physician: ...
Signature of registrar: ...
Date of registration: ...
Place of registration: ...

13487

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u> | | e. STREET ADDRESS <u>2400 Willow Glen Dr</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Samuel</u> Middle <u>Schwartz</u> Last <u>Schwartz</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>14</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/26/1881</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min. <u>59</u> | 11. IF UNDER 24 HRS.
Hours <u>19</u> Min. <u>59</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Rumania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jacob Schwartz</u> | | 14. MOTHER'S MAIDEN NAME <u>Jennie ?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>350 X</u> | |
| 17. INFORMANT <u>Elyse Schwartz</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Menstrua - apoplexy.</u>
DUE TO <u>Atherosclerosis CV Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Parasitosis</u>
(b) <u>Parasitosis</u>
(c) <u>Parasitosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Jan 1st</u> , 19 <u>57</u> , to <u>Dec 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>59</u> , and that death occurred at <u>7:12</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>M. Paul Byerly</u> M.D. | | ADDRESS (Street, city or town, state) <u>3033 W. North Ave Baltimore 16 Md</u> | |
| PHYSICIAN'S NAME (Type) <u>M. Paul Byerly</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/15/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Young Men's</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Haus</u> | | ADDRESS <u>1124-26 W. North Ave</u> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u> | |
| DATE <u>DEC 18 '59</u> | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be a medical or legal record.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2c Film G253 12/24/59 iwk

13488

CERTIFICATE OF DEATH

Reg. Dist. No. 13466

| | | | | | | | | |
|---|--|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Towson</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | c. LENGTH OF STAY IN 1b
<u>4 1/2</u> yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore 4312 Belvieu Avenue 15. Md.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Stella Maris Hospice</u> | | | | d. STREET ADDRESS
<u>Garrison Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Joseph William Schwarzkopf</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>12 9 1959</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
<u>11/28/1870</u> | | |
| 9. AGE (In years last birthday) yrs.
<u>89</u> | | IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Shipping Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Joseph Schwarzkopf</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Growe</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>220-07-7838</u> | | 17. INFORMANT Address
<u>Mae W. Segerman-33 Dunkirk Rd. Balto. 12 Md.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u>
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 Days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>Dec 19 1959</u> to <u>Dec 19 1959</u> , that I last saw the deceased alive on <u>Dec 19 1959</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>7501 York Rd 12/24/59</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell- M.D.</u> | | | | <u>Towson 4/27/64</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/12/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
<u>Wm Cook-Towson, Inc. 1050 York Rd. Towson 4, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE
<u>DEC 11 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARKETPLACE STATE DEPARTMENT OF HEALTH--BALTIMORE 10

23

EST-20-055

EST-20-055

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13489

CERTIFICATE OF DEATH

13467

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN 1b
3 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | d. STREET ADDRESS
434 S. Oriole Avenue | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle W. Last SCOTT | | | | 4. DATE OF DEATH
Month December Day 18 Year 19 59 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 18, 1890 | |
| 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months 69 Days 69 Hours 69 Min. | | IF UNDER 24 HRS.
Months 69 Days 69 Hours 69 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bottler | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Brewery | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Charles E. Scott | | | | 14. MOTHER'S MAIDEN NAME
Nellie Creamer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
216-01-4422 | | | |
| 17. INFORMANT
Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) THROMBOSIS OF ANTERIOR INFERIOR CEREBELLAR ARTERY
449X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO
(c) UNKNOWN | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that VA attended the deceased from December 15, 1959 to December 18, 1959 and that death occurred at 2:00 PM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John W. Crawford | | | | ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIV. | | | |
| DATE SIGNED 12/18/59 | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. | | | | VAH, BALTO. 18, MD. FT. HOWARD, DIVISION 12/18/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
12/22/59 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Bohemian National Cemetery Baltimore, Maryland | | | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Schimunek Funeral Home - 3331 Brehms Lane | | | | 24a. REC'D BY REGISTRAR
DEC 22 '59 | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13468

13490

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
p. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonleigh. Baltimore 12 md</u> | |
| c. LENGTH OF STAY IN <u>12</u> | | d. STREET ADDRESS <u>1910 Overbrook Road</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>910 Overbrook Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mrs EDITH Scott</u> | | 4. DATE OF DEATH <u>Dec 10 1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-25-1882</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>SAMUEL Eppler</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Elgen Fritz</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Mrs Edythe Harrison</u> | | Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Recent)</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis Generalized</u>
DUE TO (c) <u>Coronary Sclerosis + Insufficiency</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old myocardial Infarction - Hypertension</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 19, 1959</u> to <u>Dec 10, 1959</u> , that I last saw the deceased alive on <u>Dec 10, 1959</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE <u>Walter A Anderson</u> M.D. | | <u>3001 Shannon Drive</u> | |
| PHYSICIAN'S NAME (Type) <u>WALTER A ANDERSON</u> | | <u>Bethesda Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-13-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u> | | 22d. LOCATION (City, town, or county) (State) <u>Marysville PA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u> ADDRESS <u>5209 York Rd</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 14 59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Calvin S. Knaus</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13334

CERTIFICATE OF DEATH

Reg. Dist. No.

13469

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | | | c. LENGTH OF STAY IN 1b
53 Dundalk | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
3500 Louth Road | | | | d. STREET ADDRESS
3500 Louth Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First IDA Middle SEABURY Last SEABURY | | | | 4. DATE OF DEATH
Month December Day 25 Year 19 59 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 9, 1874 | |
| 9. AGE (In years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months 85 Days 85 Hours 85 Min. | | IF UNDER 24 HRS.
Months 85 Days 85 Hours 85 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At home | | | | 10b. KIND OF BUSINESS OR INDUSTRY
New York | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John J. Leverich | | | | 14. MOTHER'S MAIDEN NAME
Sarah Sniffen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No. | | | | 16. SOCIAL SECURITY NO.
Informant | | | |
| | | | | Address
Mrs. Madeline S. Mead, 3500 Louth Road-22 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema
420.0 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) 6 years
(c) 12 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 12-25-59 to 12-25-59 , that I last saw the deceased alive on 12-25-59 , and that death occurred at 9:25 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE See David | | | | ADDRESS (Street, city or town, state) 2900 Dunbar Rd. Dundalk-22-Ind | | | |
| PHYSICIAN'S NAME (Type) B.W. SALLAD, M.D. | | | | DATE SIGNED 12-26-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/26/50 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillside Cemetery | | 22d. LOCATION (City, town, or county) (State)
Peekskill, N.Y. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home 2112 Dundalk Ave. | | | | 24a. REC'D BY REGISTRAR
DEC 30 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

888



CERTIFICATE OF DEATH

Reg. Dist. No.

13470

13491

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | c. LENGTH OF STAY IN 1b
Owings Mills | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
11420 Reisterstown Road | | | | e. STREET ADDRESS
11420 Reisterstown Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) MARY C. W. SEIM | | | | 4. DATE OF DEATH
Month Dec. Day 18 Year 19 59 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 30, 1874 | |
| 9. AGE (In years lost birthday)
85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME
Frederick Wehrenberg | | | | 14. MOTHER'S MAIDEN NAME
Minnie Suchting | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) None | | INFORMANT Address
Mr. J. Fred Ningard-11420 Reisterstown Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, acute
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
Minutes
Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from November , 19 59 to Dec 18 , 19 59 that I last saw the deceased alive on Dec 5 , 19 59 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Reisterstown, Maryland
DATE SIGNED Dec 18, 1959
ACTUAL SIGNATURE Clarence E. McWilliams M.D.
PHYSICIAN'S NAME (Type) Clarence E. McWilliams | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/21/59 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Paul's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Violetville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Tichner & Sons
Baltimore, Md. | | | | 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. House | |

1-1-10

CERTIFICATE OF DEATH

1911

1

1



CERTIFICATE OF DEATH

Reg. Dist. No. ✓

13492

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO. CITY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSSVILLE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 137 N KENWOOD AVE. 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9305 PHILA RD #6 | | | | d. STREET ADDRESS 137 N KENWOOD AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) DAISY | | First V Middle S Last SELTZER | | 4. DATE OF DEATH DEC 20 1959 | | Month DEC Day 20 Year 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV 17, 1878 | | 9. AGE (In years last birthday) 81 yrs. | IF UNDER 1 YEAR
Months 8 Days 3 Hours 15 Min. | IF UNDER 24 HRS.
Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES K SELTZER | | | | 14. MOTHER'S MAIDEN NAME MATHILDA HOFF | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NOISE | | INFORMANT MRS HENRY J HOFFMEISTER | | Address 9305 PHILA RD #6 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 174X Intestinal Obstruction
DUE TO (b) Carcinoma - Pteris
DUE TO (c) Arteriosclerosis Generalized | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arthritis - generalized | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II & item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 20, 1959 to Dec 20, 1959 that I last saw the deceased alive on Dec 20, 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Louis F. Klimes M.D. | | ADDRESS (Street, city or town, state) 2623 E. Monument St. BALTO MARYLAND | | DATE SIGNED 12/21/59 | | | |
| PHYSICIAN'S NAME (Type) LOUIS F. KLIMES M.D. | | 22a. REC'D BY REGISTRAR DEC 23 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/23/59 | | 22c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT | | 22d. LOCATION (City, town, or county) (State) BALTO MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jessie Funeral Home | | | | ADDRESS 7401 Belair Rd #6 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

STATE OF NEW YORK
COUNTY OF ...
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the ... day of ... 1923, at the residence of the deceased, I examined the body of ... who had died at the residence of the deceased, and I found that the cause of death was ...
I further certify that the deceased was ... years of age, and that the death was ...
Witness my hand and the seal of my office, this ... day of ... 1923.
Signature of Physician
Seal of Office
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the ... day of ... 1923, at the residence of the deceased, I examined the body of ... who had died at the residence of the deceased, and I found that the cause of death was ...
I further certify that the deceased was ... years of age, and that the death was ...
Witness my hand and the seal of my office, this ... day of ... 1923.
Signature of Physician
Seal of Office

13493

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|---|---|---|----------|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN lb
4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Maryland
b. COUNTY
Baltimore
3V01-4
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
NICK --- SENANES | | | 4. DATE OF DEATH
Month Day Year
December 2 19 59 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 27, 1888 | | 9. AGE (In years last birthday) yrs.
71 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Proprietor-Owner | | 10b. KIND OF BUSINESS OR INDUSTRY
Lunch Room | 11. BIRTHPLACE (State or foreign country)
Greece | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Paul Senanes | | | 14. MOTHER'S MAIDEN NAME
Helen Fatorea | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
213-09-4335 | INFORMANT Address
Clin. Rec. VAH, Baltimore 18, Md. Ft. Howard Division | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
422.1 DUE TO
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
(b) DUE TO
CEREBRAL THROMBOSIS
(c)
INTERVAL BETWEEN ONSET AND DEATH
1 HOUR
UNKNOWN
RECENT | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS- Duration Unknown | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
VA 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from November 28, 1959 to December 2, 1959 , that the deceased was living on and that death occurred at 1:20AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
VAH, BALTO. 18, MD. FT. HOWARD DIVISION 12/2/59
ACTUAL SIGNATURE John W. Crawford
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION 12/2/59 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-7-59 | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 4 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | |

13433

CERTIFICATE OF DEATH

13433

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.

13494

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood | | | | c. LENGTH OF STAY IN 1b 7 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8212 Bellona Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle N. Last Sewell, Jr. | | | | 4. DATE OF DEATH Month December Day 3 Year 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 5, 1950 | |
| 9. AGE (In years last birthday) 9 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | | |
| 11. BIRTHPLACE (State or foreign country) USA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Joseph N. Sewell, Sr. | | | | 14. MOTHER'S MAIDEN NAME Rose Cox | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. INFORMANT Address Joseph N. Sewell, Sr. (Above) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 587.3 Congestive Heart Failure
DUE TO (b) Chronic Bronchopneumonia 3wPs.
DUE TO (c) Fibrocystic Disease of Pancreas Birth | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 10/4 , 19 55 , to 12/3 , 19 59 , that I last saw the deceased alive on 12/3 , 19 59 , and that death occurred at 9:25 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. A. Niermann M.D. | | | | ADDRESS (Street, city or town, state) 6229 N. Charles St. DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) WM. A. NIERMANN | | | | Baltimore 12, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-7-59 | | 22c. NAME OF CEMETERY OR CREMATORY Parkwood | | 22d. LOCATION (City, town, or county) (State) Parkville Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Baltimore 12, Md. | | | | 24a. REC'D BY REGISTRAR DEC 7 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

1340

CENTRAL T. O. B. A. H.

Salisbury

Highwood

8212 Bellows Ave.

Joseph

White

Stanton

Joseph A. Sawell, Jr.

Highland

Highland

Joseph A. Sawell, Jr. (above)

1

General

12-1-33

Henry A. Jenkins & Sons Co., 1305 York St.

Parryville

Reg. Dist. No.

13495

13474

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | c. LENGTH OF STAY IN 1b 35 YEARS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 913 ESSEX AVE. #21 MD | | d. STREET ADDRESS 913 ESSEX AVE #21 MD. | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle M. Last SHAFFER. | | 4. DATE OF DEATH Month DEC Day 26 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT 5, 1887 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER | | 10b. KIND OF BUSINESS OR INDUSTRY BETHLEH. STEEL | |
| 11. BIRTHPLACE (State or foreign country) YORK PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE B SHAFFER. | | 14. MOTHER'S MAIDEN NAME LYDIA KOONTZ. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W. I | | 16. SOCIAL SECURITY NO. 213-07-7473 | |
| INFORMANT MRS. CHARLS M. SHAFFER. | | Address 913 ESSEX AVE. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive Arterio-sclerotic Heart Disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inguinal hernia left - | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month Day 19 Year | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore | | 20f. (City or town) 21 May (County) (State) | |
| 21. I certify that I attended the deceased from Oct 9, 1958 to Dec. 18, 1959 , that I lost saw the deceased alive on December 24, 1959 , and that death occurred at 3:04 PM , from the causes and on the date stated above. Dec. 26, 1959 ADDRESS (Street, city or town, state) 7840 Eastern Ave - Balt. 24, 1959 DATE SIGNED 12/26/59 | | | |
| ACTUAL SIGNATURE MANUEL P. DE LEON | | M.D. | |
| PHYSICIAN'S NAME (Type) MANUEL P. DE LEON | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF DEC 29, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY MT PROSPECT CEM. | | 22d. LOCATION (City, town, or county) (State) SEVEN VALLEYS MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lashin Funeral Home | | ADDRESS #6. 7401 BELAIR ROAD | |
| 24a. REC'D BY REGISTRAR DATE DEC 29 '59 | | 24b. REGISTRAR'S SIGNATURE | |

1871

STATE OF OHIO

1871

IN SENATE,
January 11, 1871.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1870.
COLUMBUS:
PUBLISHED BY
J. W. FLEMING,
PRINTER,
1871.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13475

13495

| | | | | | | | |
|--|------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural-Parkton</u> | | c. LENGTH OF STAY IN 1b
<u>47 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural-Parkton</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Rayville Rd.</u> | | | | d. STREET ADDRESS
<u>Rayville Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Elmer Ellsworth Shaver, Jr.</u> | | | | 4. DATE OF DEATH Month Day Year
<u>Dec. 31 1959</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 26 1912</u> | | 9. AGE (In years last birthday)
<u>47</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Parkton, Md. R.D.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>E. E. Shaver, Sr.</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Mary S. Wilson</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT address
<u>Mary S. Shaver, Parkton, Md. R. D.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shot gun wound of the head</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u>
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Instant</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Shot himself in the head with a 12 gauge shotgun</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>5.30</u> <u>Dec. 31 1959</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Farm</u> | | 20f. (City or town) (County) (State)
<u>Parkton, Baltimore, Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>A. M. France</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED <u>Dec. 31, 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial Jan. 2, 1960</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Zion Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Freeland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jacob Hartenstein, New Freedom, Pa.</u> | | | | 24a. REC'D BY REGISTRAR
<u>JAN 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. France</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13497

CERTIFICATE OF DEATH

13476

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Hyde | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
× Rural- Hyde | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Merryland Farms-Hyde, Md. | | d. STREET ADDRESS
Merryland Farms-Hyde, Md | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Daniel (Danny) O.C. Shea | | 4. DATE OF DEATH
Month December Day 15 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 17, 1897 |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Horse Breeder | | 10b. KIND OF BUSINESS OR INDUSTRY
Horse Breeding | |
| 11. BIRTHPLACE (State or foreign country)
Massachusetts | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James E. Shea | | 14. MOTHER'S MAIDEN NAME
Mary O'Connell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Yes WWII and WWII | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Elizabeth W. Shea-Merryland Farms, Hyde, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month 19 Day 19 Year 1959
Hour a. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 1957 to present , that I last saw the deceased alive on December 10, 1959 , and that death occurred at 401 Medical Arts Bldg , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 401 Medical Arts Bldg DATE SIGNED 12-15-59
ACTUAL SIGNATURE John Russell Davis
PHYSICIAN'S NAME (Type) John Russell Davis | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/18/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. John's | | 22d. LOCATION (City, town, or county) (State)
Long Green Pike, Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm Cook-Towson, Inc. | | 24a. REC'D BY REGISTRAR
DEC 17 '59 | |
| ADDRESS
1050 York Rd. Towson, Md. | | 24b. REGISTRAR'S SIGNATURE
Curtis L. Hines | |

Appendix

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. He pays 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY | | 13498 | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Pikesville | | c. LENGTH OF STAY IN 1b | |
| Baltimore | | MARYLAND | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Pikesville | | d. STREET ADDRESS | |
| Pikesville | | 6803 Greenspring Avenue | | 6803 Greenspring Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 4. NAME OF DECEASED
(Type or print) | | SCOTT | | SILVERS | | 4. DATE OF DEATH | | December 18, 19 59 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10-29-1959 | | 10 yrs. 1 21 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| None | | | | Baltimore Md | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| John Silvers | | Lucille LeCompte | | | | | | John Silvers - same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | Pneumonia | | 493X | | DUE TO | |
| | | (b) | | | | | | | |
| | | (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 19 | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | William V. Lovitt, Jr., M.D. | | DATE SIGNED | | 12/18/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) | | (State) | |
| Burial | | 12-20-59 | | Okech Sholom | | Balto | | Md | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | |
| Jack Lewis Inc | | 2100 Eutaw Place | | DATE DEC 22 '59 | | Arthur S. Huns | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13478

13499

| | | | | | | | |
|--|---------------------------|---|---------------------------------------|--|-----------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Balto</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | | | c. LENGTH OF STAY IN 1b <u>life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Rd</u> | | | | d. STREET ADDRESS <u>Belair Rd. Fullerton PO.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lester Benjamin Simms</u> First Middle Last | | | | 4. DATE OF DEATH <u>Dec. 12</u> Month Day Year <u>1959</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 18th 1923</u> | 9. AGE (In years last birthday) <u>36</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Paving</u> | | 11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Chas. E. Simms</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hattie M. Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-16-742</u> | | 17. INFORMANT <u>Mrs. Lester Simms</u> Address <u>Belair Rd Fullerton Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb.</u> , 1957, to <u>Dec.</u> , 1959, that I last saw the deceased alive on <u>Dec. 12</u> , 1959, and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>12-13-59</u>
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/16/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u> ADDRESS <u>7401 Belair Rd</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 18 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Orin E. Kenna</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13500 CERTIFICATE OF DEATH

13479

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>BALTO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALDWIN</u> | | | | c. LENGTH OF STAY IN 1b <u>1 yr</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALDWIN</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LONG GREEN PIKE</u> | | | | d. STREET ADDRESS <u>LONG GREEN PIKE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>BARBARA R SIMS</u> First Middle Last | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1959</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MARCH 14, 1878</u> | |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>CHRISTIAN MAST</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MELINDA BEERS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | INFORMANT <u>JOHN E. SIMS</u> Address <u>BALDWIN MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>434.4 Cardiac Disease</u>
DUE TO (b) <u>Cerebral Hemorrhage</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 day</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 16, 1959</u> to <u>Dec 16, 1959</u> that I last saw the deceased alive on <u>Dec 16, 1959</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Walter M. Hammett</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>BALDWIN MD</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Walter M. Hammett</u> | | | | DATE SIGNED <u>Dec 17, 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-14-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN'S CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>LONG GREEN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS, SON</u> ADDRESS <u>8802 HARTFORD RD</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 21 '59</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

CERTIFICATE OF DEATH

1911

NO

10110

Baltimore

1111

Baltimore

Long Green Pike

Long Green Pike

Baltimore

March 11, 1890

March 11, 1890

Maryland

Maryland

John F. Jones

John F. Jones

Baltimore

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

John F. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13480

Reg. Dist. No.

13501

| | | | | | | | |
|---|--|---|-------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparrows Point | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bethlehem Steel Company Dispensary | | | | d. STREET ADDRESS
402 S. Bonsal Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle J. Last SKRUCH | | | | 4. DATE OF DEATH
Month 12 Day 31 Year 19 59 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/2/1917 | | 9. AGE (In years last birthday)
42 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pit foreman | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel | | 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Josrph Skruch | | | | 14. MOTHER'S MAIDEN NAME
Mary C. Baranowska | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
213-09-3942 | | 17. INFORMANT Address
Agnes Skruch 402 S. Bonsal St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Crushing injury and burn (4th deg.) of lower portion of right side of body. Traumatic amputation and burn of left arm.
 DUE TO 9/12.3
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 60%;"> (b) _____
 DUE TO _____
 (c) _____ </div> </div> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Ingot buggy toppled over onto deceased. | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
5:15 AM 12/31/59 | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Steel Mill | | 20f. (City or town)
Sparrows Point, Md | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE M B Davis | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/4/1960 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 22d. LOCATION (City, town, or county)
Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Weber & Sons Inc | | | | ADDRESS
401 S. Chestern St | | 24a. REC'D BY REGISTRAR
DATE JAN 4 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | |
| JAMES J. HENRY | | 45 | | M | | W | | 10/10/1910 | |
| RESIDENCE | | BIRTHPLACE | | MARRIAGE | | EDUCATION | | OCCUPATION | |
| 100 N. BOSTON ST. | | MASS. | | 1865 | | HIGH SCHOOL | | LABORER | |
| FATHER'S NAME | | MOTHER'S NAME | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CAUSE OF DEATH | |
| JAMES J. HENRY | | MARY J. HENRY | | 1885 | | MASS. | | HEART DISEASE | |
| DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | | TIME OF DEATH | |
| 10/10/1910 | | MASS. | | 10/10/1910 | | MASS. | | 10:00 AM | |
| TEMPERATURE | | PULSE | | RESPIRATION | | BLOOD PRESSURE | | URINE | |
| 98.6 | | 72 | | 18 | | 120/80 | | NORMAL | |
| STOMACH | | LUNGS | | LIVER | | SPLEEN | | PANCREAS | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| KIDNEYS | | BLADDER | | PROSTATE | | VAGINA | | UTERUS | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| TESTES | | OVARIES | | TUBES | | PERITONEUM | | MUSCLES | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| BONES | | JOINTS | | SKIN | | HAIR | | TEETH | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| EYES | | EARS | | NOSE | | MOUTH | | THROAT | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| LARYNX | | TRACHEA | | BRONCHI | | PULMONES | | DIAPHRAGM | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| HEART | | PERICARDIUM | | AORTA | | PULMONARY ARTERY | | VASCULAR SYSTEM | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| DIGESTIVE SYSTEM | | RESPIRATORY SYSTEM | | CIRCULATORY SYSTEM | | EXCRETORY SYSTEM | | REPRODUCTIVE SYSTEM | |
| NORMAL | | NORMAL | | NORMAL | | NORMAL | | NORMAL | |
| GENERAL APPEARANCE | | MANNER OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | TIME OF DEATH | |
| GOOD | | NATURAL | | HOME | | 10/10/1910 | | 10:00 AM | |
| SIGNATURE OF EXAMINER | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | | DATE OF DEATH | | TIME OF DEATH | |
| J. J. HENRY | | 10/10/1910 | | MASS. | | 10/10/1910 | | 10:00 AM | |
| TESTIMONY OF WITNESSES | | TESTIMONY OF WITNESSES | | TESTIMONY OF WITNESSES | | TESTIMONY OF WITNESSES | | TESTIMONY OF WITNESSES | |
| J. J. HENRY | | J. J. HENRY | | J. J. HENRY | | J. J. HENRY | | J. J. HENRY | |
| J. J. HENRY | | J. J. HENRY | | J. J. HENRY | | J. J. HENRY | | J. J. HENRY | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13502

CERTIFICATE OF DEATH

Reg. Dist. No.

13481

| | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Woodlawn
c. LENGTH OF STAY IN b
3 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
6631 Dogwood Rd. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Woodlawn, Baltimore Co.
d. STREET ADDRESS
6631 Dogwood Rd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Alice | | First
L. | | Middle
Slattery | | Last
Dec. | | 4. DATE OF DEATH
Month
4
Day
19
Year
59. | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 20-1876 | | 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months
83 | | IF UNDER 24 HRS.
Days
83
Hours
83
Min.
83 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Hildibrand | | | | | | 14. MOTHER'S MAIDEN NAME
Smith | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
-- | | | | 16. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Wm. Slattery (Son)
Address
Sulphur Spring Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
442X
DUE TO
Cerebral Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
Cardio-Vascular-Renal disease
DUE TO
(c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Baltimore | | (County)
Baltimore | | (State)
Md. | | | |
| 21. I certify that I attended the deceased from 11/28 , 19 57 , to 12/4 , 19 57 , that I last saw the deceased alive on 11/27 , 19 57 , and that death occurred at 6 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
4710 Liberty St. Balt. Md.
DATE SIGNED
12/7/57 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
[Signature] | | | | M.D.
U. J. VOLENICK MD | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type)
U. J. VOLENICK MD | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
Dec. 7-1959. | | 22c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
[Signature] | | | | | | ADDRESS
5646 Carville Ave. | | 24a. REC'D BY REGISTRAR
DEC 8 '59 | | 24b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

CERTIFICATE OF DEATH

1920

| | | | | | | | | | |
|-----------------------|--|----------------------------|--|----------------------------|--|-----------------------------------|--|------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | | 5. Place of death | |
| 6. Cause of death | | 7. Nature of disease | | 8. Duration of disease | | 9. Name of physician | | 10. Name of funeral director | |
| 11. Name of informant | | 12. Signature of informant | | 13. Signature of physician | | 14. Signature of funeral director | | 15. Signature of registrar | |
| 16. Name of registrar | | 17. Signature of registrar | | 18. Signature of registrar | | 19. Signature of registrar | | 20. Signature of registrar | |
| 21. Name of registrar | | 22. Signature of registrar | | 23. Signature of registrar | | 24. Signature of registrar | | 25. Signature of registrar | |
| 26. Name of registrar | | 27. Signature of registrar | | 28. Signature of registrar | | 29. Signature of registrar | | 30. Signature of registrar | |
| 31. Name of registrar | | 32. Signature of registrar | | 33. Signature of registrar | | 34. Signature of registrar | | 35. Signature of registrar | |
| 36. Name of registrar | | 37. Signature of registrar | | 38. Signature of registrar | | 39. Signature of registrar | | 40. Signature of registrar | |
| 41. Name of registrar | | 42. Signature of registrar | | 43. Signature of registrar | | 44. Signature of registrar | | 45. Signature of registrar | |
| 46. Name of registrar | | 47. Signature of registrar | | 48. Signature of registrar | | 49. Signature of registrar | | 50. Signature of registrar | |
| 51. Name of registrar | | 52. Signature of registrar | | 53. Signature of registrar | | 54. Signature of registrar | | 55. Signature of registrar | |
| 56. Name of registrar | | 57. Signature of registrar | | 58. Signature of registrar | | 59. Signature of registrar | | 60. Signature of registrar | |
| 61. Name of registrar | | 62. Signature of registrar | | 63. Signature of registrar | | 64. Signature of registrar | | 65. Signature of registrar | |
| 66. Name of registrar | | 67. Signature of registrar | | 68. Signature of registrar | | 69. Signature of registrar | | 70. Signature of registrar | |
| 71. Name of registrar | | 72. Signature of registrar | | 73. Signature of registrar | | 74. Signature of registrar | | 75. Signature of registrar | |
| 76. Name of registrar | | 77. Signature of registrar | | 78. Signature of registrar | | 79. Signature of registrar | | 80. Signature of registrar | |
| 81. Name of registrar | | 82. Signature of registrar | | 83. Signature of registrar | | 84. Signature of registrar | | 85. Signature of registrar | |
| 86. Name of registrar | | 87. Signature of registrar | | 88. Signature of registrar | | 89. Signature of registrar | | 90. Signature of registrar | |
| 91. Name of registrar | | 92. Signature of registrar | | 93. Signature of registrar | | 94. Signature of registrar | | 95. Signature of registrar | |
| 96. Name of registrar | | 97. Signature of registrar | | 98. Signature of registrar | | 99. Signature of registrar | | 100. Signature of registrar | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BRANCH 10

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| Item 18 Film 254 1-12-60 ans | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|--|---|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 13508 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 19482 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Academy Avenue | | | | | d. STREET ADDRESS
Academy Avenue | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) CATHERINE VIRGINIA SMITH | | | | | 4. DATE OF DEATH
Month December Day 9 Year 1959 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 14, 1919 | | 9. AGE (In years last birthday) 40 yrs. | | |
| | | | | | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| | | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | | | |
| | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
Lawrence Robenson | | | | | 14. MOTHER'S MAIDEN NAME
Louise Latlief | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
213-20-7536 | | | | | |
| | | | | | 17. INFORMANT
Address
John W. Smith Owings Mills, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial pneumonitis
525X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE
W. Bradley King, Jr., M.D. | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | DATE SIGNED
12/9/59 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 22b. DATE THEREOF
Dec. 12, 59 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Louis Cemetery | | 22d. LOCATION (City, town, or country) (State)
Clarksville Md. | |
| 23. FUNERAL DIRECTOR
J.F. Eline & Sons | | | | | ADDRESS
Reisterstown, Md. | | | | | |
| 24a. REC'D BY REGISTRAR
DEC 11 '59 | | | | | 24b. REGISTRAR'S SIGNATURE
Charles E. Kinnard | | | | | |

MEDICAL CERTIFICATION

2

2

BP

100-100000



100-100000

100-100000

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13504

CERTIFICATE OF DEATH

13483

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baldwin (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baldwin (Rural) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Green Road | | d. STREET ADDRESS
Green Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle SMITH Last SMITH | | 4. DATE OF DEATH
Month Dec. Day 25 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 18, 1877 |
| 9. AGE (In years last birthday) yrs.
82 | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Conrad C. Smith | | 14. MOTHER'S MAIDEN NAME
Caroline Ledder | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-34-5951 | |
| INFORMANT
Augusta B. Smith-Green Rd. Baldwin, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Infarction
434.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Sudden death
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 20 to Dec 25 , 19 59 , that I last saw the deceased alive on Dec 20 , 19 59 , and that death occurred at 6:00 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Baldwin, Md. SIGNED
ACTUAL SIGNATURE Halter M. Hammett M.D. Baldwin
PHYSICIAN'S NAME (Type) Halter M. Hammett Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/29/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm Cook-Towson, Inc. York Rd. Towson 4, Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 28 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13484

Reg. Dist. No.

13505

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>
c. LENGTH OF STAY IN 1b <u>LIFE</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>401 JEFFERSON AVE.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>
d. STREET ADDRESS <u>308 E. PA. AVE.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LEONARD LORRAINE SMITH</u>
First Middle Last | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1959</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>July 2, 1906</u> | |
| 9. AGE (In years, last birthday) <u>53</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>JAS. H. SMITH</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>CLARA WATKINS</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W. W. II</u> | | | |
| 16. SOCIAL SECURITY NO. <u>216 014192</u> | | | | 17. INFORMANT <u>ALICE CHEVER-2813 PRESBURYST</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____
(c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> | | | | DATE SIGNED <u>12/27/59</u> | | | |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>12/30/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. S. Blumenthal</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 29 '59</u> | | | |
| ADDRESS <u>1701 Michigan St. Balto, Md.</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13506

CERTIFICATE OF DEATH

13485

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
3yr5mths | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D. C. 16X-2 | |
| f. STREET ADDRESS
14 and Clifton Streets | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Patrick Middle Robert Last Somers | | 4. DATE OF DEATH
Month December Day 19 Year 1959 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 21, 1912 |
| 9. AGE (In years last birthday)
46 yrs. | | IF UNDER 1 YEAR
Months 46 Days 46 Hours 46 Min. | IF UNDER 24 HRS.
Months 46 Days 46 Hours 46 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
stove assembler | | 10b. KIND OF BUSINESS OR INDUSTRY
West Virginia | |
| 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James Somers | | 14. MOTHER'S MAIDEN NAME
Agnes Kinney | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition and dehydration
355X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mental Disease (Schizophrenia) DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH
months
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 17, 1959 , to Dec. 19, 1959 , that I last saw the deceased alive on Dec. 19, 1959 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Bruno Radawski M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12/19/59 | |
| PHYSICIAN'S NAME (Type) BRUNO RADALUSKAS | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
12/23/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Jones Co | | ADDRESS 2901 14th St. N.W. | |
| 24a. REC'D BY REGISTRAR
DEC 23 '59 | | 24b. REGISTRAR'S SIGNATURE
Charles L. K... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13486

13507

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE - 7 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X -- | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
3621 Patterson Ave. | | d. STREET ADDRESS
3621 Patterson Ave. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle SORRELL Last SORRELL | | 4. DATE OF DEATH
Month Dec. Day 12 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Apr. 18, 1872 |
| 9. AGE (In years last birthday)
87 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Rtd | | 10b. KIND OF BUSINESS OR INDUSTRY
Monitor Controller | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Thomas Sorrell | | 14. MOTHER'S MAIDEN NAME
Annie - | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
INFORMANT Address
Mrs. Margaret Keen - 3621 Patterson Ave. #7 | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.
(b) with congestive heart failure
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hiatus hernia | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 30 March, 1954 to 12 Dec, 1959 that I last saw the deceased alive on 19 Dec, 1959 , and that death occurred at 9:00 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Marvin H. Davis | | ADDRESS (Street, city or town, state)
MARVIN H. DAVIS, M. D. | |
| PHYSICIAN'S NAME (Type)
6512 Liberty Road | | Baltimore 7, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/15/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Trakner & Sons - Balto | | ADDRESS
Md. | |
| 24a. REC'D BY REGISTRAR
DATE DEC 15 '59 | | 24b. REGISTRAR'S SIGNATURE
C. L. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13480

CERTIFICATE OF DEATH

13207

11

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 1, 1910*
5. Place of birth: *New York City*
6. Date of death: *Dec 15, 1955*
7. Place of death: *Home*
8. Cause of death: *Heart disease*
9. Signature of physician: *[Signature]*
10. Signature of registrar: *[Signature]*

11. Name of informant: *John Doe*
12. Address of informant: *123 Main St, New York City*
13. Date of report: *Dec 16, 1955*
14. Signature of informant: *[Signature]*
15. Date of filing: *Dec 17, 1955*
16. Signature of registrar: *[Signature]*
17. Date of filing: *Dec 18, 1955*
18. Signature of registrar: *[Signature]*
19. Date of filing: *Dec 19, 1955*
20. Signature of registrar: *[Signature]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13508
CERTIFICATE OF DEATH

13487

Reg. Dist. No.

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Railroad Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rodrick</u> Middle <u>W.</u> Last <u>Spittler</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 12, 1959</u> |
| 9. AGE (In years last birthday) <u>1</u> yrs. | | 10. IF UNDER 1 YEAR <input checked="" type="checkbox"/> UNDER 24 HRS. Months <u>1</u> Days <u>20</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Oral Spittler</u> | | 14. MOTHER'S MAIDEN NAME <u>Beatrice Tiffner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Oral Spittler Railroad Ave. White Marsh Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>SUFFOCATION</u>
501X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Aspiration</u>
(c) <u>Rhinitis & Bronchitis</u>
minutes | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12 30 1959</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12-12-1959</u> to <u>12-30-1959</u> that I last saw the deceased alive on <u>12-30-1959</u> and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John B. Littleton M.D.</u> | | ADDRESS (Street, city or town, state) <u>1515 MARTIN BLVD Balto 20 Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>John. B. Littleton</u> | | DATE SIGNED <u>12-30-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-30-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer, Methodist</u> | 22d. LOCATION (City, town, or county) (State) <u>Chase, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> | | ADDRESS <u>7401 Belair Rd.</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u> | |

30000000X00

CERTIFICATE OF DEATH

13502

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

[Faint, mostly illegible text follows, likely containing fields for Name, Age, Sex, Date of Death, and Cause of Death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13509
CERTIFICATE OF DEATH

Reg. Dist. No.

13488

| | | | | | | | |
|---|---------------------------|--|------------------------------------|--|--|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Latonville Rural</u> | | | | c. LENGTH OF STAY IN 1b <u>1 yr</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Ridgeway Manor-Mrs. Home</u> | | | | d. STREET ADDRESS <u>x Upperco (Rural)</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>ARTHUR - N - STANSBURY</u> | | | | 4. DATE OF DEATH <u>Dec 25</u> 19 <u>59</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 9-1885</u> | | 9. AGE (In years last birthday) <u>74</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Black & Decker</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ind</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>W.S.A</u> | |
| 13. FATHER'S NAME <u>Nelson Stansbury</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Abby Brummell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No 220-14-4411</u> | | INFORMANT <u>John Pindell - Upperco R.D. Ind</u> Address | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Embolism</u>
DUE TO <u>Cardio-Vascular Disease with</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>decompensation</u>
lying cause last. (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
<u>1 month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11.25.59</u> to <u>12.25.59</u> , that I last saw the deceased alive on <u>12.24.59</u> , and that death occurred at <u>12:55 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edgar E. Urban</u> | | | | ADDRESS (Street, city or town, state) <u>805 Snd. Ave 28th</u> DATE SIGNED <u>12.26.59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Edgar E. URBAN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-28-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u> | | 22d. LOCATION (City, town, or county) (State) <u>Reisterstown-Balto Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Tipton</u> ADDRESS <u>Hampstead Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 29 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

AP

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13489

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sparrows Point
c. LENGTH OF STAY IN 1b
53
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Bethlehem Steel Dispensary | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk
d. STREET ADDRESS
2500 Yorkway
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
CHARLES RICHARD STEALEY, Sr | | 4. DATE OF DEATH
Month Day Year
December 7, 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1903
Sept. 9, 1905 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pipe fitter | | 10b. KIND OF BUSINESS OR INDUSTRY
Shipyard | |
| 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles C. Stealey | | 14. MOTHER'S MAIDEN NAME
Elizabeth Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
235-12-2267 | |
| 17. INFORMANT
Mrs. Anna Stealey | | Address
2500 Yorkway | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Russell S. Fisher | | M.D.
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
12/7/59 | |
| EXAMINER'S NAME (Type)
Russell S. Fisher, M.D. | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/10/59 | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | 22d. LOCATION (City, town, or country) (State)
Colgate, Md. |
| 23. FUNERAL DIRECTOR
Ullrich Funeral Home Dundalk, Md. | | 24a. REC'D BY REGISTRAR
DEC 14 '59
24b. REGISTRAR'S SIGNATURE
Crosby S. Kraus | |

10120

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13490

13511

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort Howard</u> | | c. LENGTH OF STAY IN 1b
<u>55 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Veterans Administration Hospital</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>3V01-4</u> | |
| 4. DATE OF DEATH (Type or print)
First Middle Last
<u>LEROY</u> <u>R</u> <u>STEINER</u> | | 5. DATE OF DEATH
Month Day Year
<u>December</u> <u>29</u> <u>19 59</u> | |
| 6. SEX
<u>Male</u> | 7. COLOR OR RACE
<u>white</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. DATE OF BIRTH
<u>September 30, 1932</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Buyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Machinery Shop</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.A</u> | |
| 13. FATHER'S NAME
<u>Louis Steiner</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillian Block</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>215-28-3671</u> | |
| 17. INFORMANT
<u>Clin. Rec. Vet. Adm. Hosp. Balto Md Ft Howard Div.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>SHOCK</u>
DUE TO <u>POST OPERATIVE SUB TOTAL COLECTOMY</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>ULCERATIVE COLITIS</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>Acute</u>
<u>7 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>VA</u> <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>November 14, 19 59</u> , to <u>December 29, 19 59</u> , and that death occurred at <u>9:20 AM</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>James R. Powder</u> | | ADDRESS (Street, city or town, state)
<u>VAH BALTO MD FT HOWARD DIVISION</u> | |
| PHYSICIAN'S NAME (Type)
<u>JAMES R. POWDER, M.D.</u> | | DATE SIGNED
<u>12/29/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-30-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>United Hebrew Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jack Lewis</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 30 59</u> | |
| ADDRESS
<u>2100 Entaw Place Balto. Md</u> | | 24b. REGISTRAR'S SIGNATURE
<u>CHAS. S. FURUEA</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1934

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.



Vertical text on the far right edge, possibly a page number or reference code.

CERTIFICATE OF DEATH

Reg. Dist. No.

13491

13512

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Balto. 3701.4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Summit Nursing Home-98 Smithwood Ave. | | d. STREET ADDRESS
1411 S. Carey St. | |
| 3. NAME OF DECEASED (Type or print)
First DAISY Middle M. Last STEWART | | 4. DATE OF DEATH
Month Dec. Day 5, Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 15, 1879 |
| 9. AGE (In years last birthday)
80 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
-- Burgess | | 14. MOTHER'S MAIDEN NAME
Agnes -- | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
-- | | 16. SOCIAL SECURITY NO.
Informant | |
| 17. ADDRESS
Mrs. Dollie Tracey - 402 Lee Drive | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accidents
331x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple
DUE TO (c) Congrene lower extremities | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blot | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 59 , 19 59 , to 12/5/59 , that I last saw the deceased alive on 12/5/59 , and that death occurred at 11:15 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md DATE SIGNED 12/7/59 | |
| ACTUAL SIGNATURE W. E. McGroth M.D. | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | |
| PHYSICIAN'S NAME (Type)
W. E. McGroth | | 22b. DATE THEREOF
12/9/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 22d. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Vickers & Sons - Balto. Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 8 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur B. Krause | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15101

CERTIFICATE OF DEATH

1911

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CERTIFICATE OF DEATH

Reg. Dist. No.

13492

13513

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Washington b. COUNTY DC | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | c. LENGTH OF STAY IN 1b
3 mon. 11 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
College Manor Aged Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First FRANCES Middle K Last STILLWELL | | 4. DATE OF DEATH
Month December Day 14 , Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 1, 1878 |
| 9. AGE (In years last birthday) yrs.
81 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (State or foreign country)
Chicago, Illinois | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Rollin Keys | | 14. MOTHER'S MAIDEN NAME
Katherine Keys | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
None | |
| INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO years
(c) Generalized arteriosclerosis DUE TO years | | | INTERVAL BETWEEN ONSET AND DEATH
6 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept , 19 59 , to present , 19 59 , that I last saw the deceased alive on Sept 12 , 19 59 , and that death occurred at 12:45 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Ernest C Brown Jr | | ADDRESS (Street, city or town, state) DATE SIGNED
M.D. 1101 N. Calvert St., Balt-2 Md 12-14-59 | |
| PHYSICIAN'S NAME (Type)
Ernest C. Brown, Jr. | | 1101 N. Calvert St., Baltimore 2, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal/Burial | 22b. DATE THEREOF
12-16-59 | 22c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | 22d. LOCATION (City, town, or county) (State)
Montgomery County, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Gaylor's Sons, 1756 Penna. Ave., Wash. D.C.
John Burns' Sons, Towson, Maryland | | 24a. REC'D BY REGISTRAR
DATE DEC 17 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

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VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

Washington

Washington, D.C.

Age 22 years

Birthplace

2200 California Avenue, NW

Johnston and Home

STANDARD

STANDARD

December 11, 1921

April 1, 1908

White

Chicago, Illinois

Chicago, Illinois

Johnston

Hospital records

Recorded

Johnston and Home, 2200 California Avenue, NW, Washington, D.C.

13514

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|-----------------------|--|--|--|--|--|--|---|--|
| MEDICAL CERTIFICATION | 1. CAUSE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓ | | | |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Owings Mills, Md.</u> | | c. LENGTH OF STAY IN 1b
<u>5 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown, Maryland</u> <u>2103-2</u> | | d. STREET ADDRESS
<u>724 Washington Avenue</u> | |
| | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Rosewood State Training School</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | 3. NAME OF DECEASED
(Type or print) | | First <u>Patricia</u> Middle <u>Ann</u> Last <u>Stotelmeyer</u> | | 4. DATE OF DEATH | | Month <u>12</u> Day <u>22</u> Year <u>19 59</u> | |
| | 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12/17/53</u> | |
| | 9. AGE (In years last birthday)
<u>6</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ | | | |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
_____ | | 10b. KIND OF BUSINESS OR INDUSTRY
_____ | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| | 13. FATHER'S NAME
<u>Lewis Victor Stotelmeyer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Frances Wharton</u> | | | |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
_____ | | INFORMANT
<u>Rosewood Records</u> | | Address
_____ | |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Microcephaly with broncho-pneumonia and otitis media</u>
753.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| | 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. _____ 19____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| | 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:16 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave Baltimore 14, Md</u> DATE SIGNED <u>12/22/59</u> | | | | | | | |
| | ACTUAL SIGNATURE <u>Peter W. Rieckert</u> | | PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u> | | | | | |
| | 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/23/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Hagerstown Wash Co Md</u> | |
| | 23. FUNERAL DIRECTOR'S SIGNATURE
<u>1715 Baltimore Hagerstown Md</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 28 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/5B

UNITED STATES OF AMERICA

1934

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13515

CERTIFICATE OF DEATH

13494

Reg. Dist. No.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
9 years | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
53 Dundalk, Md. | | d. STREET ADDRESS
26 Midship Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Joseph | | First | | Middle
Strapple | | Last | | 4. DATE OF DEATH
Dec. 26 19 59 | | Month | | Day | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
March 13, 1911 | | 9. AGE (In years last birthday) yrs.
48 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
odd jobs | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Penna | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
Anthony Strapple | | 14. MOTHER'S MAIDEN NAME
ANNA Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
192-01-8688 | | 17. INFORMANT
Spring Grove State Hospital's Records | | Address | | | | | | | |

| | | | | | | | | | | | |
|--|--|-------------------|--|--|--|--|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal pneumonia
345X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple sclerosis
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec. 24 , 19 59 to Dec. 26 , 19 59 , that I last saw the deceased alive on Dec. 26 , 19 59 , and that death occurred at 8:10a M, from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE Stella Wachslar | | | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL | | | | DATE SIGNED 12-28-59 | | | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | | | Catonsville 28, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | 1/14/60 | | St. John's | | Somerset Co. Pa. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Kelpko Funeral Home | | | | ADDRESS
Madras & Son, Windber, Pa. | | 24a. REC'D BY REGISTRAR
JAN 4 '60 | | 24b. REGISTRAR'S SIGNATURE
Charles E. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13495

13516

| | | | |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Balto. Co.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>md</i> b. COUNTY <i>Balto.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | | c. LENGTH OF STAY IN 1b <i>52</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Caton Ridge Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Harry C. Stultz</i> | | 4. DATE OF DEATH <i>Dec. 21 1959</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11/26/66</i> |
| 9. AGE (In years lost birthday) <i>93</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumbing</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Wm. A. Stultz</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna Williams</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>Madeline Castle</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Arteriosclerosis</i>
DUE TO <i>Coronary Ar.</i>
(c) <i>Age</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs</i>
<i>Unknown</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>July</i> , 19 <i>58</i> , to <i>Dec 21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 21</i> , 19 <i>59</i> , and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Cliff Ratliff Jr.</i> M.D. <i>4605 Edmore Ave</i> | | 12/23/59 | |
| PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF JR.</i> | | <i>Balto. Co. md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/24/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Staten Reformed Ch.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Middleton Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Ratliff + don</i> | | ADDRESS <i>28</i> | |
| 24a. REC'D BY REGISTRAR <i>DEC 28 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i> | |

14108

CERTIFICATE OF DEATH

1921

1

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and cause of death.]



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| <div>Items 20&21 Film 254</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>18517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>13496</div> | | | | | | | | | |
|--|--|---|-------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
52 Catonsville | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
2411 Rockwell Ave. (garage) | | | | | d. STREET ADDRESS
2411 Rockwell Ave., | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
GEORGE S. SULLIVAN | | | | | 4. DATE OF DEATH
December 10, 1959 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 26, 1905 | | 9. AGE (In years last birthday)
54 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plumber | | 10b. KIND OF BUSINESS OR INDUSTRY
Plumbing | | 11. BIRTHPLACE (State or foreign country)
Carroll Co. Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S?A | | |
| 13. FATHER'S NAME
Frank B. Sullivan | | | | | 14. MOTHER'S MAIDEN NAME
Carrie Blizzard | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-05-9357 | | 17. INFORMANT
Hazel M. Sullivan 2411 Rockwell Ave., | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon monoxide poisoning
891.0 DUE TO
Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Inhaled carbon monoxide while sitting in an automobile | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Undetermined 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
garage | | 20f. (City or town)
Catonsville | | 20g. (County)
Balto. | |
| 20h. (State)
Md. | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
William V. Lovitt, Jr., M.D. | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ADDRESS | | DATE SIGNED
12/10/59 | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 14, 59 | | 22c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 22d. LOCATION (City, town, or country) (State)
Baltimore County, Maryland | | | |
| 23. FUNERAL DIRECTOR
William Cook Inc. 1217 St. Paul St., | | | | 24a. REC'D BY REGISTRAR
DEC 14 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur J. Hensel | | | |

U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D.C. 20501
1881



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13497

13518

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Monkton | | | | c. LENGTH OF STAY IN 16
74 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Ada Frances Swift | | | | 4. DATE OF DEATH Month Day Year
Dec. 9 19 59 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 28, 1985 | |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Monkton, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13. FATHER'S NAME
Lewis M. Troyer | | | | 14. MOTHER'S MAIDEN NAME
Eliza Jane Melvin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
217-36-2685 D | | | |
| 17. INFORMANT Address
Miss. Jane Swift Monkton, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the colon
DUE TO
(b) _____
DUE TO
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio vascular disease | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Oct. 3 , 19 59 , to Dec. 9 , 19 59 , that I last saw the deceased alive on Dec. 9 , 19 59 , and that death occurred at 8 PM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Monkton, Md. DATE SIGNED 12/10/59
ACTUAL SIGNATURE A. M. France M.D. A. M. France
PHYSICIAN'S NAME (Type) A. M. France | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/12/1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Wesley Chapel | | 22d. LOCATION (City, town, or county) (State)
Monkton Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles C. Kurtz | | | | ADDRESS
Garrettsville Md. | | 24a. REC'D BY REGISTRAR
DEC 14 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13498

13519

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 YRS CATONSVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE 52</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES</u> | | | | d. STREET ADDRESS <u>2122 ALVIN AVE.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EDWARD THOMPSON</u> | | | | 4. DATE OF DEATH Month Day Year <u>DEC. 9, 1959</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JUNE 1, 1872</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METER READER & REPAIRS GAS & ELECT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CO.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | | | | | | |
| 13. FATHER'S NAME <u>OLIVER THOMPSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ANNIE HAMILTON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-264959</u> | | 17. INFORMANT <u>2217 PLEASANT DR. CATONSVILLE, MD.</u> <u>MRS. VICTOR BUETE FISC</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coxsack Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcohol poisoning</u>
DUE TO (c) <u>unknown</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia Bilateral</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 10, 1922</u> , to <u>Dec 8, 1959</u> , that I last saw the deceased alive on <u>Dec 8, 1959</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D. | | | | DATE SIGNED <u>12/14/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u> | | | | <u>BALTO 29, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12/12/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u> | | | | ADDRESS <u>CATONSVILLE, MD.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 14 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **13499**

13520

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
55 Towson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1732 Amuskai Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle H. Last Traband | | 4. DATE OF DEATH
Month December Day 12 , Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 10, 1899 |
| 9. AGE (In years last birthday) yrs.
60 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | 11. IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Store Keeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Crown Cork & seal | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Traband | | 14. MOTHER'S MAIDEN NAME
Clara Emge | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
214-05-3484 | |
| 17. INFORMANT
Mrs. Nellie Traband | | Address
1732 Amuskai Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Parkinson's disease
350x DUE TO (b) Generalized arterio sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 yr | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/15 , 19 48 , to 12/12 , 19 59 , that I last saw the deceased alive on 12/12 , 19 59 , and that death occurred at 1030 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 8513 Loch Raven Bldg DATE SIGNED 12/14/59 | | | |
| ACTUAL SIGNATURE Gordon Grau | | M.D. 8513 Loch Raven Bldg | |
| PHYSICIAN'S NAME (Type) Gordon Grau, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-15-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Moreland Park | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lassahn Funeral Home | | 24a. REC'D BY REGISTRAR
DATE DEC 18 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

10000

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13521

CERTIFICATE OF DEATH

13500

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS
10706 Reisterstown Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle Edward Last Turnbaugh | | 4. DATE OF DEATH
Month December Day 12 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 6, 1888 |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
handy man | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Louis Turnbaugh | | 14. MOTHER'S MAIDEN NAME
Martha | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
216-14-4815 | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion
(c) Generalized Arteriosclerotic Cardiovascular Dis. | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 29, 19 59 to Dec. 12, 19 59 , that I last saw the deceased alive on Dec. 4, 19 59 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Edward T. Schmor M.D. SPRING GROVE STATE HOSPITAL
PHYSICIAN'S NAME (Type) Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Dec 15-1959 | 22c. NAME OF CEMETERY OR CREMATORY
Reisterstown Meth. Cemetery | 22d. LOCATION (City, town, or county) (State)
Reisterstown Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Oliver L. Bervyman | | ADDRESS
Reisterstown, Md. | 24a. RECEIVED BY REGISTRAR
DATE DEC 15 59 |
| | | 24b. REGISTRAR'S SIGNATURE
Charles L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15251

CERTIFICATE OF DEATH

15251

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Page One of Two

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. PLACE OF BIRTH
MOBILE, ALABAMA | |
| 3. DATE OF BIRTH
JANUARY 5, 1928 | | 4. PLACE OF BIRTH
MOBILE, ALABAMA | |
| 5. DATE OF DEATH
APRIL 4, 1968 | | 6. PLACE OF DEATH
MEMPHIS, TENNESSEE | |
| 7. CAUSE OF DEATH
HEART DISEASE | | 8. MANNER OF DEATH
NATURAL | |
| 9. SEX
MALE | | 10. RACE
WHITE | |
| 11. OCCUPATION
PUBLISHER | | 12. EDUCATION
HIGH SCHOOL | |
| 13. MARITAL STATUS
MARRIED | | 14. RELIGION
METHODIST | |
| 15. SIGNATURE OF DECEASED
JAMES EARL RAY | | 16. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 17. SIGNATURE OF DECEASED
JAMES EARL RAY | | 18. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 19. SIGNATURE OF DECEASED
JAMES EARL RAY | | 20. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 21. SIGNATURE OF DECEASED
JAMES EARL RAY | | 22. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 23. SIGNATURE OF DECEASED
JAMES EARL RAY | | 24. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 25. SIGNATURE OF DECEASED
JAMES EARL RAY | | 26. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 27. SIGNATURE OF DECEASED
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| 29. SIGNATURE OF DECEASED
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| 31. SIGNATURE OF DECEASED
JAMES EARL RAY | | 32. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 33. SIGNATURE OF DECEASED
JAMES EARL RAY | | 34. SIGNATURE OF WITNESS
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| 37. SIGNATURE OF DECEASED
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| 39. SIGNATURE OF DECEASED
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| 97. SIGNATURE OF DECEASED
JAMES EARL RAY | | 98. SIGNATURE OF WITNESS
JAMES EARL RAY | |
| 99. SIGNATURE OF DECEASED
JAMES EARL RAY | | 100. SIGNATURE OF WITNESS
JAMES EARL RAY | |

1. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 4th day of April, 1968.

2. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 4th day of April, 1968.

3. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 4th day of April, 1968.

4. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 4th day of April, 1968.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13501

13337

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Halethorpe | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Halethorpe 51 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
2034 Northeast Ave | | | | d. STREET ADDRESS
2034 Northeast Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Walter T. Turner | | | | 4. DATE OF DEATH
Month December Day 18 Year 19 59 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jul. 1, 1891 | | 9. AGE (In years last birthday)
68 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Sidney ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Gladys C. Turner Address 2034 Northe ast Av | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aortic Stenosis
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary insufficiency
DUE TO
(c) Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs approx |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-26 , 19 58 , to 11-26 , 19 59 , that I last saw the deceased alive on 11-26 , 19 59 , and that death occurred at 3 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE
H Wasserman | | | | M.D. 1501 Eutaw Place | | | |
| PHYSICIAN'S NAME (Type) Dr. Harry Wasserman | | | | Baltimore 17 MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-22-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 22d. LOCATION (City, town, or county) (State)
Balto. Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arthur S. Frank | | | | ADDRESS 578 W. Biddle St. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |
| | | | | 24a. REC'D BY REGISTRAR
DATE DEC 28 '59 | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13502

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> 13522
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u>
c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1024 Crosby Rd.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>52 Catonsville</u>
d. STREET ADDRESS
<u>1024 Crosby Rd.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Sallie</u> Middle <u>Peirce</u> Last <u>Tyler</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>18</u> , Year <u>1959</u> | |
| 5. SEX
<u>Fem</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 19, 1927</u> |
| 9. AGE (In years last birthday)
<u>32</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John M. Peirce</u> | | 14. MOTHER'S MAIDEN NAME
<u>Estelle Ray</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Yes</u> | |
| 17. INFORMANT
<u>Mr. Kohn W. Tyler -1024 Crosby Rd.28</u> | | Address

 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gas poisoning From Automobile</u>
DUE TO <u>Carbon monoxide. Asphyxiation</u>
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(c), stating the underlying cause lost. DUE TO <u>Suicide</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>
<u>973.1</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Rubber tube attached to exhaust of Auto, into carcausing death by Car. Monoxide</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>How - 30 A. M. 12.18.59</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Garage at home</u> | 20f. (City or town)
<u>Catonsville Balto. Md</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Geo. S. M. Kieffer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>Geo. S. M. Kieffer M.D.</u> | | DATE SIGNED
<u>Dec. 18, 1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | 22b. DATE THEREOF
<u>12/21/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Warsaw Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Warsaw, North Carolina</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. J. Tickner & Sons - Balto - 17 Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 21 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13523

CERTIFICATE OF DEATH

13503

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

CHARLES H. VINSON

2. DATE OF DEATH

Dec. 29, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Armacost Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

1423 Kingsway Rd.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Dec. 18, 1872

9. AGE (In years last birthday)

87

If Under 1 Year

Months Days Hours Min

If Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Light House

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Vinson

14. MOTHER'S MAIDEN NAME

Elizabeth Zeis

15. Was Deceased Ever in U.S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

Miss Anna V. Vinson - 1423 Kingsway Rd.

ADDRESS

18. 155.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)
DUE TO(B)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

6 weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

Dec 29

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒WORK ☐ AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from December 29, 1959 to December 29, 1959, that (I) (no) last saw the deceased alive on December 26, 1959, and that in (my) (our) opinion death occurred at 6:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

A. Allan Smith

M.D.

23B. ADDRESS

4408 Loch Raven Blvd

23C. DATE SIGNED

12/29/59

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/31/59

24C. NAME OF CEMETERY OR CREMATORY

Western Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY REGISTRAR

DEC 30 1959

REGISTRAR'S SIGNATURE

Arthur S. Hume

25. FUNERAL DIRECTOR

Wm. L. Tucker & Sons, Inc.

ADDRESS

THIS IS A PERMANENT RECORD

PLEASE TYPE, OR IN PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN
Every item of information carefully supplied. Physicians: please write the causes of death clearly and legibly.
THIS CERTIFICATE MUST BE THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER D

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13504

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Essex
c. LENGTH OF STAY IN 1b
Essex
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Middle River Rd. and Martin Blvd. | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
54 Baltimore
d. STREET ADDRESS
407 A Ballard Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
GEORGE DAVID VOLZ
First Middle Last
5. SEX
Male
6. COLOR OR RACE
White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH
October 7, 1897
9. AGE (In years last birthday)
62 yrs.
IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | | 4. DATE OF DEATH
December 14 19 59
Month Day Year | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
General Laborer
10b. KIND OF BUSINESS OR INDUSTRY
Maryland
11. BIRTHPLACE (State or foreign country)
U.S.A.
12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
David Volz
14. MOTHER'S MAIDEN NAME
Lena Richert | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No
16. SOCIAL SECURITY NO.
7 Volz Avenue
17. INFORMANT
Henry Volz
Address
7 Volz Avenue | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extensive third degree burns and carbon monoxide poisoning complicating massive fresh intracerebral hemorrhage in white matter of left lower parietal lobe.
916.8 DUKDO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO
(c) Hypertensive arteriosclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Deceased was found in burning shack containing xmas trees.
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased was found in burning shack containing xmas trees. | |
| 20c. TIME OF INJURY
Month, Day, Year
2:30 Hour a.m. 12 14 59 p.m. 19
20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Parking lot
20f. (City or town) (County) (State)
Essex Baltimore Maryland | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Russell S. Fisher
EXAMINER'S NAME (Type)
Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
12/14/59
Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL
22b. DATE THEREOF
DEC 16, 1959
22c. NAME OF CEMETERY OR CREMATORY
ZION LUTHERN CEM.
22d. LOCATION (City, town, or country) (State)
STEMMERS RUN. MARYLAND | | 23. FUNERAL DIRECTOR
Jessahn Funeral Home 7401 Belair Road #6
ADDRESS
24a. REC'D BY REGISTRAR
DEC 17 '59
24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

MAILED
JAN 10 1934

7

RECEIVED
JAN 10 1934

1934

1934

MAILED
JAN 10 1934

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JAN 10 1934

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JAN 10 1934

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JAN 10 1934

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13505**

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown 1/2 hr. | | c. LENGTH OF STAY IN lb
1 1/2 hr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockdale Balto 7. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Randallstown 2nd St | | | | d. STREET ADDRESS
3823 Washington Ave | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
HENRY CLIFTON WAGNER | | | | 4. DATE OF DEATH
Month Dec Day 21 Year 1959 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan 9, 1896 | 9. AGE (In years last birthday)
63 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Insurance Agent. Life Insurance | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Eustace Wagner | | | | 14. MOTHER'S MAIDEN NAME
Pauline Myers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No. | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Mrs Myrtle E. Wagner Address 3823 Washington Ave | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Angina Pectoris
420.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
no | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. none p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State)
none. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED Dec 21 '59 | |
| EXAMINER'S NAME (Type) D. D. CAPLES, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/24/59 | | 22c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 22d. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Loring Byers | | | | ADDRESS
8728 Liberty Road, Randallstown, Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 24 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH
& COUNTY

HABITATION

CAUSE OF DEATH

AGE

SEX

DATE OF
BIRTH

DATE OF
DEATH

IMMEDIATE CAUSE OF DEATH
IMMEDIATE CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

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IMMEDIATE CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

5750 Liberty Road,
Baltimore, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13506

| | | | |
|---|---------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>52</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>313 Sutter Ave. Apt B.</u> | | d. STREET ADDRESS
<u>313 Sutter Ave. Apt. B</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Abraham</u> Middle <u>Walters</u> Last | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>28</u> Year <u>1959</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 1889</u> |
| 9. AGE (In years last birthday)
<u>70</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Chauffeur</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Ind.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>218 10 3144</u> | |
| 17. INFORMANT
<u>Mrs. Lula Walters</u> | | Address
<u>313 Sutter Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
DUE TO (b) <u>Cardiovascular disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<u>Geo. S. M. Kieffer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>Geo. S. M. Kieffer M.D</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
<u>Dec. 28, 1959</u> | |
| 22a. BURIAL, CREMATION, or OTHER (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/31/1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Lukes Cem. Balto.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>William R. Williams</u> | | ADDRESS
<u>322 N. Howard St</u> | |
| 24a. REC'D BY REGISTRAR
<u>DEC 31 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 7 Film 6254 1-8-60 et
 13527 CERTIFICATE OF DEATH

13507
 Reg. Dist. No. 32

| | | | | | | | |
|--|------------------------------|---|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Hartford</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mt. Wilson, Maryland</u> | | | | c. LENGTH OF STAY IN 1b
<u>6 mo.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Mt. Wilson State Hospital</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>3714 R.D.#2, Loppa, Md.</u> | | | |
| | | | | d. STREET ADDRESS
<u>12X-2</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Emanuel</u> Middle <u>Chester</u> Last <u>Waters</u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>31</u> Year <u>1959</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/29/1882</u> | 9. AGE (In years last birthday)
<u>77</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Machine Shop</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Benjamin Waters</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Viola May Henry</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | | 17. INFORMANT Address
<u>Hospital Records, Mt. Wilson State Hospital</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Far Advanced Pulmonary Tuberculosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/5</u> , 19 <u>54</u> , to <u>12/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/31</u> , 19 <u>54</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE _____ M.D. <u>Mt. Wilson, Maryland</u>
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u> Superintendent | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
<u>Jan 3, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Stateville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>York Co. Penna</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>H.S. Bailey</u> | | | | 24b. REC'D BY REGISTRAR
DATE <u>JAN 5 '60</u> | | 24c. REGISTRAR'S SIGNATURE
<u>Cathy L. Kane</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED
<i>John Doe</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>Jan 15 1950</i> | | 5. TIME OF DEATH
<i>10:30 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Heart Disease</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 10. DATE OF BIRTH
<i>Jan 15 1905</i> | | 11. TIME OF BIRTH
<i>10:30 AM</i> | | 12. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 13. NAME OF FATHER
<i>John Doe</i> | | 14. NAME OF MOTHER
<i>John Doe</i> | | 15. NAME OF SPOUSE
<i>John Doe</i> | |
| 16. NAME OF CHILDREN
<i>John Doe</i> | | 17. NAME OF CHILDREN
<i>John Doe</i> | | 18. NAME OF CHILDREN
<i>John Doe</i> | |
| 19. NAME OF CHILDREN
<i>John Doe</i> | | 20. NAME OF CHILDREN
<i>John Doe</i> | | 21. NAME OF CHILDREN
<i>John Doe</i> | |
| 22. NAME OF CHILDREN
<i>John Doe</i> | | 23. NAME OF CHILDREN
<i>John Doe</i> | | 24. NAME OF CHILDREN
<i>John Doe</i> | |
| 25. NAME OF CHILDREN
<i>John Doe</i> | | 26. NAME OF CHILDREN
<i>John Doe</i> | | 27. NAME OF CHILDREN
<i>John Doe</i> | |
| 28. NAME OF CHILDREN
<i>John Doe</i> | | 29. NAME OF CHILDREN
<i>John Doe</i> | | 30. NAME OF CHILDREN
<i>John Doe</i> | |
| 31. NAME OF CHILDREN
<i>John Doe</i> | | 32. NAME OF CHILDREN
<i>John Doe</i> | | 33. NAME OF CHILDREN
<i>John Doe</i> | |
| 34. NAME OF CHILDREN
<i>John Doe</i> | | 35. NAME OF CHILDREN
<i>John Doe</i> | | 36. NAME OF CHILDREN
<i>John Doe</i> | |
| 37. NAME OF CHILDREN
<i>John Doe</i> | | 38. NAME OF CHILDREN
<i>John Doe</i> | | 39. NAME OF CHILDREN
<i>John Doe</i> | |
| 40. NAME OF CHILDREN
<i>John Doe</i> | | 41. NAME OF CHILDREN
<i>John Doe</i> | | 42. NAME OF CHILDREN
<i>John Doe</i> | |
| 43. NAME OF CHILDREN
<i>John Doe</i> | | 44. NAME OF CHILDREN
<i>John Doe</i> | | 45. NAME OF CHILDREN
<i>John Doe</i> | |
| 46. NAME OF CHILDREN
<i>John Doe</i> | | 47. NAME OF CHILDREN
<i>John Doe</i> | | 48. NAME OF CHILDREN
<i>John Doe</i> | |
| 49. NAME OF CHILDREN
<i>John Doe</i> | | 50. NAME OF CHILDREN
<i>John Doe</i> | | 51. NAME OF CHILDREN
<i>John Doe</i> | |
| 52. NAME OF CHILDREN
<i>John Doe</i> | | 53. NAME OF CHILDREN
<i>John Doe</i> | | 54. NAME OF CHILDREN
<i>John Doe</i> | |
| 55. NAME OF CHILDREN
<i>John Doe</i> | | 56. NAME OF CHILDREN
<i>John Doe</i> | | 57. NAME OF CHILDREN
<i>John Doe</i> | |
| 58. NAME OF CHILDREN
<i>John Doe</i> | | 59. NAME OF CHILDREN
<i>John Doe</i> | | 60. NAME OF CHILDREN
<i>John Doe</i> | |
| 61. NAME OF CHILDREN
<i>John Doe</i> | | 62. NAME OF CHILDREN
<i>John Doe</i> | | 63. NAME OF CHILDREN
<i>John Doe</i> | |
| 64. NAME OF CHILDREN
<i>John Doe</i> | | 65. NAME OF CHILDREN
<i>John Doe</i> | | 66. NAME OF CHILDREN
<i>John Doe</i> | |
| 67. NAME OF CHILDREN
<i>John Doe</i> | | 68. NAME OF CHILDREN
<i>John Doe</i> | | 69. NAME OF CHILDREN
<i>John Doe</i> | |
| 70. NAME OF CHILDREN
<i>John Doe</i> | | 71. NAME OF CHILDREN
<i>John Doe</i> | | 72. NAME OF CHILDREN
<i>John Doe</i> | |
| 73. NAME OF CHILDREN
<i>John Doe</i> | | 74. NAME OF CHILDREN
<i>John Doe</i> | | 75. NAME OF CHILDREN
<i>John Doe</i> | |
| 76. NAME OF CHILDREN
<i>John Doe</i> | | 77. NAME OF CHILDREN
<i>John Doe</i> | | 78. NAME OF CHILDREN
<i>John Doe</i> | |
| 79. NAME OF CHILDREN
<i>John Doe</i> | | 80. NAME OF CHILDREN
<i>John Doe</i> | | 81. NAME OF CHILDREN
<i>John Doe</i> | |
| 82. NAME OF CHILDREN
<i>John Doe</i> | | 83. NAME OF CHILDREN
<i>John Doe</i> | | 84. NAME OF CHILDREN
<i>John Doe</i> | |
| 85. NAME OF CHILDREN
<i>John Doe</i> | | 86. NAME OF CHILDREN
<i>John Doe</i> | | 87. NAME OF CHILDREN
<i>John Doe</i> | |
| 88. NAME OF CHILDREN
<i>John Doe</i> | | 89. NAME OF CHILDREN
<i>John Doe</i> | | 90. NAME OF CHILDREN
<i>John Doe</i> | |
| 91. NAME OF CHILDREN
<i>John Doe</i> | | 92. NAME OF CHILDREN
<i>John Doe</i> | | 93. NAME OF CHILDREN
<i>John Doe</i> | |
| 94. NAME OF CHILDREN
<i>John Doe</i> | | 95. NAME OF CHILDREN
<i>John Doe</i> | | 96. NAME OF CHILDREN
<i>John Doe</i> | |
| 97. NAME OF CHILDREN
<i>John Doe</i> | | 98. NAME OF CHILDREN
<i>John Doe</i> | | 99. NAME OF CHILDREN
<i>John Doe</i> | |
| 100. NAME OF CHILDREN
<i>John Doe</i> | | 101. NAME OF CHILDREN
<i>John Doe</i> | | 102. NAME OF CHILDREN
<i>John Doe</i> | |

Vertical text on the right side of the page.

Vertical text on the far right edge of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13528

CERTIFICATE OF DEATH

Reg. Dist. No.

13508

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN Tb | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>402 Regester Ave.</u> | | d. STREET ADDRESS
<u>402 Regester Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARIA</u> Middle <u>EMMA</u> Last <u>WELCH</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>26</u> Year <u>1959</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 26, 1875</u> |
| 9. AGE (In years last birthday)
<u>84</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>retired Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Public School</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>Mordecai Welch</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rhoda Armiger</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | |
| 17. INFORMANT
<u>Miss Rhoda Hamilton</u> | | Address
<u>402 Regester Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Left Kidney</u>
<u>180x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular</u>
DUE TO <u>Disease</u>
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 mos.</u>
<u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hiatus Hernia Dextro cardia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 23</u> , 19 <u>59</u> , to <u>Dec 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>59</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>William F. Raxe</u> M.D. | | ADDRESS (Street, city or town, state)
<u>2105 N Charles St</u> | |
| DATE SIGNED
<u>12/28/59</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Baltimore 18 Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/29/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Brooklyn, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Mar. J. Lockner</u> | | ADDRESS
<u>Balto 17 Md</u> | |
| 24a. REC'D BY REGISTRAR
<u>DEC 28 59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Hines</u> | |

CERTIFICATE OF DEATH

1928

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p> | | <p>2. SEX</p> <p><i>Male</i></p> | |
| <p>3. AGE</p> <p><i>45</i></p> | | <p>4. DATE OF BIRTH</p> <p><i>Jan 15 1883</i></p> | |
| <p>5. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p> | | <p>6. OCCUPATION</p> <p><i>Teacher</i></p> | |
| <p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p> | | <p>8. PLACE OF DEATH</p> <p><i>Home</i></p> | |
| <p>9. TIME OF DEATH</p> <p><i>10:30 AM</i></p> | | <p>10. DATE OF DEATH</p> <p><i>Dec 10 1928</i></p> | |
| <p>11. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p> | | <p>12. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p> | |
| <p>13. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p> | | <p>14. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p> | |



RECEIVED
 BALTIMORE
 DECEMBER 11 1928
 HEALTH DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13335

CERTIFICATE OF DEATH

Reg. Dist. No.

13509

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b
3 Mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sons Residence, 114 Wise Ave. | | e. IS RESIDENCE ONLY A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Agnes Middle Katherine Last West | | 4. DATE OF DEATH
Month December Day 24 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 18, 1885 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-Employed | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Lawrence Drozdowski | | 14. MOTHER'S MAIDEN NAME
Katherine ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO.
212-129-9777 | |
| 17. INFORMANT
Dr. Charles West | | Address
114 Wise Ave. 22, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
10 years
one day | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 59 , to December , 19 59 , that I last saw the deceased alive on December 24 , 19 59 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
John V. Conway, M.D. | | ADDRESS (Street, city or town, state)
914 D Street | |
| PHYSICIAN'S NAME (Type)
John V. Conway, M.D. | | DATE SIGNED
12-28-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-28-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 22d. LOCATION (City, town, or county) (State)
Dundalk Ave. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Duda | | ADDRESS
7922 Wise Ave. 22, Md. | |
| 24a. REC'D BY REGISTRAR
DATE DEC 29 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

CEPHALOPOD DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13510

13529

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines | | d. STREET ADDRESS 11 S. Woodington Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) HENRIETTA WICKS | | 4. DATE OF DEATH Dec. 9, 1959 | |
| 5. SEX female | | 6. COLOR OR RACE white | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 28, 1874 | |
| 9. AGE (In years lost birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME James Stewart | | 14. MOTHER'S MAIDEN NAME Emilie Ford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address Miss Margaret S. Wicks-11 S. Woodington Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Advanced arteriosclerotic and hypertensive cardio-vascular disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10 May, 1955 to 9 Dec, 1959 that I last saw the deceased alive on 9 Dec, 1959 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 601 Winans Way DATE SIGNED 10 Dec 59 | | | |
| ACTUAL SIGNATURE Emil H Henning Jr M.D. | | | |
| PHYSICIAN'S NAME (Type) EMIL H HENNING JR MD | | 601 WINANS WAY (29) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/12/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner & Sons - Balto ADDRESS 17th Ma | | 24a. REC'D BY REGISTRAR DATE DEC 14 59 | |
| | | 24b. REGISTRAR'S SIGNATURE Charles S. Hines | |

DEPARTMENT OF HEALTH - BUREAU OF HEALTH

1952

10

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13530

CERTIFICATE OF DEATH

Reg. Dist. No. 13511

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> | | c. LENGTH OF STAY IN 1b <u>13 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Eura Katherine Wilhelm</u> | | 4. DATE OF DEATH Month Day Year <u>December 20, 1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 25, 1900</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pizarro, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Thomas L. Kelley</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Abigail Vest</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>L</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 days</u> DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec. 15, 1959</u> to <u>Dec. 20, 1959</u> that I last saw the deceased alive on <u>Dec. 19, 1959</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>G. M. France</u> M.D. | | ADDRESS (Street, city or town, state) <u>PARKTON, Md.</u> DATE SIGNED <u>12/21/59</u> | |
| PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/23/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Foreston Baptist Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Parkton, Md. R.D.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 24 '59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u> | |

CERTIFICATE OF DEATH

1901

1

[Faint, illegible text, likely bleed-through from the reverse side of the document]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13512

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>8 DUNDALK AVE</u> | | | | d. STREET ADDRESS
<u>18214 NORTHVIEW RD</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LEE MACE WILLEY SR</u> | | | | 4. DATE OF DEATH <u>DEC 16</u> 19 <u>59</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JUNE 21 1901</u> | 9. AGE (In years last birthday)
<u>58</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SHAPING FOREMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>STEEL</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>ISAIAH WILLEY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>EMMA HURLEY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>MRS VIDA WILLEY</u> Address <u>8214 NORTHVIEW RD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u>
<u>443X</u> DUE TO (b) <u>Int Antic - Intest Stenosis & Obstruction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
<u>Aspirin</u> | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<u>M.B. Davis</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
<u>12/17/59</u> | | | |
| EXAMINER'S NAME (Type)
<u>M.B. Davis M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>12/19/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>OAK LAWN CEMETERY</u> | 22d. LOCATION (City, town, or county) | (State)
<u>MD</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>ULRICH FUNERAL HOME</u> | | | ADDRESS
<u>2112 DUNDALK AVE</u> | 24a. REC'D BY REGISTRAR
<u>DEC 21 '59</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13532

CERTIFICATE OF DEATH

13513

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>51 Lansdowne</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Shady nook Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Louise</u> Middle <u>H.</u> Last <u>Wolf</u> | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>13</u> Year <u>1959</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-6-1890</u> |
| 9. AGE (In years last birthday) yrs. <u>69</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James W. Higgins</u> | | 14. MOTHER'S MAIDEN NAME
<u>Martha Griffith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. INFORMANT Address
<u>George W. Wolf</u> <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular Disease</u>
260x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Diabetes Mellitus</u> DUE TO
(c) <u>Bronchial asthma</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 26, 1958</u> to <u>December 13, 1959</u> that I last saw the deceased alive on <u>12 December, 1959</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>1118 ST PAUL ST.</u> <u>12-14-59</u> | | | |
| ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u> M.D. | | PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u> <u>BALTIMORE, 2, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 22b. DATE THEREOF
<u>12-16-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 18 '59</u> | |
| ADDRESS
<u>5305 Harford Rd</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Frank</u> | |

1323

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13533

Items 8,9 Film G253 12-24-59 et

CERTIFICATE OF DEATH

13514

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY 3V01-4 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore (7) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | d. STREET ADDRESS
3906 N. Rogers Avenue | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |

| | | | |
|--|----------------------------------|---|---|
| 3. NAME OF DECEASED (Type or print)
First MATTHEW Middle W. Last WOLPERT | | 4. DATE OF DEATH
Month December Day 16 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 28, 1892
January 15, 1890 |
| 9. AGE (In years lost birthday)
69 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 15 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Wholesale Jobber | | 10b. KIND OF BUSINESS OR INDUSTRY
Tobacco Business | |
| 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
U.S. A. | |

| | | | |
|--|--|---|--|
| 13. FATHER'S NAME
Moishe Wolpert | | 14. MOTHER'S MAIDEN NAME
Frieda Greenberg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
WW I | |
| INFORMANT
Clin. Rec. VAH, Ft. Howard Division, Balto. 18, Md. | | Address | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
420.1
DUE TO
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
1 Day
10 YRS. |
|--|--|--|

| | | |
|--|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
VA | 20d. INJURY OCCURRED
While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) |

| | | | |
|---|--|---|------------------------------------|
| 21. I certify that I attended the deceased from Dec. 16, 8:20AM '59 to Dec. 16, 2:20PM '59 and that death occurred at 2:20PM , from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state)
VAH, BALTO. 18, MD. FT. HOWARD DIVISION | 23. DATE SIGNED
12/16/59 |
| ACTUAL SIGNATURE
<i>Caridad E. Gonzalez</i> | | PHYSICIAN'S NAME (Type)
CARIDAD E. GONZALEZ, M.D. | |

| | | | |
|--|--------------------------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-17-59 | 22c. NAME OF CEMETERY OR CREMATORY
Rose Dale | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Jack Lewis Inc., 2100 Rutaw Place, Balto. Md. | | 24a. REC'D BY REGISTRAR
DEC 21 '59 | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. K...</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

10

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF REGISTRAR

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13515

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b 1yrlmth13dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 1909 Fleet Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Helen First Verdia Ester Wolski Last | | 4. DATE OF DEATH December 10 19 59 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 5, 1913 |
| 9. AGE (In years last birthday) 46 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Mr. Golden | | 14. MOTHER'S MAIDEN NAME Lena ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. 259-26-4379 | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 974x DUE TO Strangulation by hanging
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Strangulation by hanging
(c) Strangulation by hanging
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suicide
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was found at 6:45 p.m. with hem of a garment tied to a door knob and around her neck. | |
| 20c. TIME OF INJURY 6:45 p.m. | Month, Day, Year 12-10 19 59 | 20d. INJURY OCCURRED While at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital |
| 20f. (City or town) Catonsville 28, Maryland | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE George M. Kieffer | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/14/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery | | 22d. LOCATION (City, town, or county) (State) 6515 Boston St. (Balto, Md.) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber | | ADDRESS 705 South Ann Street | |
| 24a. REC'D BY REGISTRAR DEC 15 '59 | | 24b. REGISTRAR'S SIGNATURE Charles E. Hume | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

LOCAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| Reg. Dist. No. 13516 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | c. LENGTH OF STAY IN lb
<u>6yr5mth2dys</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Laurel, Maryland</u> | | | 16x-2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | | | | d. STREET ADDRESS
<u>Star Route - Box 404</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>George W. Wootten</u> | | | | | 4. DATE OF DEATH
Month Day Year
<u>Dec 6 19 59</u> | | | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1871?</u> | | 9. AGE (In years last birthday)
<u>88</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>unknown</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
Address
Records: <u>SPRING GROVE STATE HOSPITAL</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Broncho. Pneumonia</u>
<u>904.7</u> DUE TO <u>Arteriosclerotic cardio vascular disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u>
DUE TO (c) <u>Fracture right femur (accident)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell to floor on 10-24-59 sustaining fractured right femur.</u> | | | | | | |
| 20c. TIME OF INJURY
Hour <u>7:00</u> P. M. Month, Day, Year <u>10-24- 59</u> | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>hospital</u> | | 20f. (City or town)
<u>Catonsville 28, Maryland</u> | | (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <u>George M. Kieffer</u>
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | 22b. DATE THEREOF
<u>12/8/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Port Lincoln Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Calmar, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Dr. Will Donaldson</u> | | | | | ADDRESS
<u>Laurel Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 10 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Clara L. House</u> | |

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MEDICAL CERTIFICATION

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WEST AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1931

| | | | |
|----------------------------------|--|----------------------------------|--|
| NAME OF DECEASED
_____ | | SEX
_____ | |
| AGE
_____ | | RACE
_____ | |
| DATE OF DEATH
_____ | | PLACE OF DEATH
_____ | |
| TIME OF DEATH
_____ | | OCCASION OF DEATH
_____ | |
| NAME OF PHYSICIAN
_____ | | NAME OF EXAMINER
_____ | |
| ADDRESS OF DECEASED
_____ | | ADDRESS OF EXAMINER
_____ | |
| OCCUPATION OF DECEASED
_____ | | OCCUPATION OF EXAMINER
_____ | |
| CAUSE OF DEATH
_____ | | MANNER OF DEATH
_____ | |
| MEDICAL HISTORY
_____ | | SOCIAL HISTORY
_____ | |
| PHYSICAL EXAMINATION
_____ | | LABORATORY EXAMINATIONS
_____ | |
| POST-MORTEM EXAMINATION
_____ | | OTHER EXAMINATIONS
_____ | |
| SIGNATURE OF PHYSICIAN
_____ | | SIGNATURE OF EXAMINER
_____ | |
| DATE OF SIGNATURE
_____ | | DATE OF SIGNATURE
_____ | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13536

CERTIFICATE OF DEATH

Reg. Dist. No.

13517

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3401-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
House in the Pines Nursing Home | | d. STREET ADDRESS
3912 Belle Ave.. | |
| 3. NAME OF DECEASED (Type or print)
First Nettie Middle A. Last Worthman | | 4. DATE OF DEATH
Month Dec. Day 28 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 31, 1883 |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | | 10b. KIND OF BUSINESS OR INDUSTRY
Hutzler Bros. | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Worthman | | 14. MOTHER'S MAIDEN NAME
Wilhelmina Bolwie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
216-03-4958 | |
| 17. INFORMANT
Mrs. Lillian Rodgers | | Address
113 S. Wickham Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Urinary Bladder
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardio-vascular Disease | | | |
| INTERVAL BETWEEN ONSET AND DEATH
about 3 Mos. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March , 19 46 , to Dec. 28 , 19 59 , that I last saw the deceased alive on Dec. 28 , 19 59 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1 Mallow Hill Ave.. DATE SIGNED 12/29/59 | | | |
| ACTUAL SIGNATURE Leo J. Gaver M.D. | | PHYSICIAN'S NAME (Type) Leo J. Gaver | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-31-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
G. Howard Strong | | 24a. REC'D BY REGISTRAR
DATE DEC 31 '59 | |
| ADDRESS
3207 W. North Ave. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13518

13537

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
2mth2dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First George Middle W. Last Wratchford | | 4. DATE OF DEATH
Month December Day 29 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 17, 1880 |
| 9. AGE (In years last birthday)
79 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | 11. BIRTHPLACE (State or foreign country)
W. Virginia |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Unknown | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | |
| 16. SOCIAL SECURITY NO.
Has a card | | 17. INFORMANT
Address Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 26 , 19 59 , to Decm. 29 , 19 59 , that I last saw the deceased alive on Dec. 29 , 19 59 , and that death occurred at 3:35 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachsler M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-29-59 | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-2-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Catonsville Cemetery | | 22d. LOCATION (City, town, or county) (State)
Catonsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
McCully Funeral Home | | ADDRESS
305 Fox Ave | |
| 24a. REC'D BY REGISTRAR
JAN 4 60 | | 24b. REGISTRAR'S SIGNATURE
Arthur J. Smith | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13538

CERTIFICATE OF DEATH

13519

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN 1b
4 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First THOMAS Middle GORSUCH Last YOUNG, JR. | | | | 4. DATE OF DEATH
Month December Day 16 Year 19 59 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 23, 1911 | |
| 9. AGE (In years lost birthday) yrs.
48 | | 10. IF UNDER 1 YEAR
Months 4 Days 16 Hours 59 | | 11. IF UNDER 24 HRS.
Months 4 Days 16 Hours 59 | | 12. IF UNDER 24 HRS.
Months 4 Days 16 Hours 59 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore, Maryland | | | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Thomas G. Young | | | | 14. MOTHER'S MAIDEN NAME
Isabel Evans Mundy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
213-03-7474 | | | |
| 17. INFORMANT
Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC INSUFFICIENCY
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) LAENNEC'S CIRRHOSIS OF LIVER
(c) CHRONIC PEPTIC DUODENAL ULCER
INTERVAL BETWEEN ONSET AND DEATH
4 Days
SEVERAL YRS.
UNKNOWN | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. VA | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 12, 19 59 , to December 16, 19 59 , that I last saw the deceased alive on December 12, 19 59 , and that death occurred at 6:55 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) VAH, BALTO. 18, MD. FT. HOWARD DIVISION DATE SIGNED 12/16/59 | | | | | | | |
| ACTUAL SIGNATURE Caridad E. Gonzalez | | | | PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
12-18-59 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md. | | | | 24a. REC'D BY REGISTRAR
DEC 21 '59 | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

1933

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13539

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1752 1752 Aberdeen Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
George N. Zellinger Jr. | | | | 4. DATE OF DEATH
Month Day Year
December 23 19 59 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 18, 1894 | 9. AGE (In years last birthday)
65 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Boiler Makers Helper | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A |
| 13. FATHER'S NAME
George N. Zellinger Sr. | | | | 14. MOTHER'S MAIDEN NAME
Kate Lennbaum | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
WW1 213-03-2703A | | 17. INFORMANT
Address
Sophia Zellinger 1752 Aberdeen Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio sclerotic cardio-vascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from 6/15, 1957 , to 12/23, 1959 , that I last saw the deceased alive on 12/25, 1959 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Gordon Grau | | | | ADDRESS (Street, city or town, state)
1523 York River Blvd | | DATE SIGNED
12/26/59 | |
| PHYSICIAN'S NAME (Type)
Edward Gordon Grau | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/28/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Balto. National Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John A. Moran | | | | ADDRESS
3000 E. Baltimore St. Balto. | | 24a. REC'D BY REGISTRAR
DEC 29 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Gordon S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13538

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form 10-1-58

| | | | |
|---|--|--|--|
| NAME OF DECEASED
JOHN J. GARDEN | | DATE OF DEATH
10-15-58 | |
| PLACE OF DEATH
HOME | | CITY
BALTIMORE | |
| COUNTY
JOHN J. GARDEN | | STATE
MARYLAND | |
| AGE
68 | | SEX
M | |
| RACE
W | | RELIGION
R | |
| MARRIED
<input checked="" type="checkbox"/> YES | | SINGLE
<input type="checkbox"/> NO | |
| OCCUPATION
RETIRED | | CAUSE OF DEATH
HEART DISEASE | |
| DIRECT PHYSICIAN
DR. J. J. GARDEN | | INDIRECT PHYSICIAN
DR. J. J. GARDEN | |
| DATE OF BURIAL
10-15-58 | | PLACE OF BURIAL
JOHN J. GARDEN | |
| NAME OF FUNERAL HOME
JOHN J. GARDEN | | ADDRESS OF FUNERAL HOME
JOHN J. GARDEN | |
| NAME OF NEXT OF KIN
JOHN J. GARDEN | | ADDRESS OF NEXT OF KIN
JOHN J. GARDEN | |
| NAME OF WITNESS
JOHN J. GARDEN | | ADDRESS OF WITNESS
JOHN J. GARDEN | |
| NAME OF REGISTRAR
JOHN J. GARDEN | | ADDRESS OF REGISTRAR
JOHN J. GARDEN | |
| NAME OF CLERK
JOHN J. GARDEN | | ADDRESS OF CLERK
JOHN J. GARDEN | |
| NAME OF ASSISTANT CLERK
JOHN J. GARDEN | | ADDRESS OF ASSISTANT CLERK
JOHN J. GARDEN | |
| NAME OF DECEASED'S PHYSICIAN
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S PHYSICIAN
DR. J. J. GARDEN | |
| NAME OF DECEASED'S SURGEON
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S SURGEON
DR. J. J. GARDEN | |
| NAME OF DECEASED'S DENTIST
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S DENTIST
DR. J. J. GARDEN | |
| NAME OF DECEASED'S OPTICIAN
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S OPTICIAN
DR. J. J. GARDEN | |
| NAME OF DECEASED'S PHARMACEUTICIAN
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S PHARMACEUTICIAN
DR. J. J. GARDEN | |
| NAME OF DECEASED'S NURSE
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S NURSE
DR. J. J. GARDEN | |
| NAME OF DECEASED'S SOCIAL WORKER
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S SOCIAL WORKER
DR. J. J. GARDEN | |
| NAME OF DECEASED'S CHAPLAIN
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S CHAPLAIN
DR. J. J. GARDEN | |
| NAME OF DECEASED'S MINISTER
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S MINISTER
DR. J. J. GARDEN | |
| NAME OF DECEASED'S PRIEST
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S PRIEST
DR. J. J. GARDEN | |
| NAME OF DECEASED'S RABBI
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S RABBI
DR. J. J. GARDEN | |
| NAME OF DECEASED'S OTHER CLERGYMAN
DR. J. J. GARDEN | | ADDRESS OF DECEASED'S OTHER CLERGYMAN
DR. J. J. GARDEN | |

CERTIFICATE OF DEATH

Reg. Dist. No.

13521

13540

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Pikesville</u> | | c. LENGTH OF STAY IN 1b
<u>Lifetime</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Lavinia Zimmer</u> | | 4. DATE OF DEATH <u>December 11, 1959</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 13, 1883</u> |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | 11. BIRTHPLACE (State or foreign country)
<u>Baltio. Co. Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>John Henery Allers</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Lavinia Mullineaux</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> | |
| 16. SOCIAL SECURITY NO.
<u>Mr. George W. Zimmer, 217 Church Lane, Pikesville 8, Md.</u> | | 17. INFORMANT
<u>Mr. George W. Zimmer, 217 Church Lane, Pikesville 8, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Pancreas</u>
157X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>22 mons.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 24th</u> , 19 <u>58</u> , to <u>Dec. 11th</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>Dec. 11th</u> , 19 <u>59</u> , and that death occurred at <u>5⁴⁵ P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James A. Miller, M.D.</u> | | ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd., Pikesville - L. Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u> | | DATE SIGNED <u>12/13/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Dec. 14, 1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Pikesville 8, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Frank H. Havelle</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 14 '59</u> | |
| ADDRESS
<u>Pikesville, Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban complers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

10240



[Faint, mostly illegible text, likely a legal document or affidavit, with some handwritten notes and signatures visible.]